

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OHIO  
EASTERN DIVISION

---

IN RE: NATIONAL PRESCRIPTION                      MDL No. 2804  
OPIATE LITIGATION                                      Case No. 17-md-2804

This document relates to:                      Judge Dan  
   Aaron Polster

The County of Cuyahoga v. Purdue  
Pharma, L.P., et al.  
Case No. 17-OP-45005  
City of Cleveland, Ohio vs. Purdue  
Pharma, L.P., et al.  
Case No. 18-OP-45132  
The County of Summit, Ohio,  
et al. v. Purdue Pharma, L.P.,  
et al.  
Case No. 18-OP-45090

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Videotaped Deposition of Hugh Shannon

Cleveland, Ohio

January 24, 2019

9:02 a.m.

Reported by: Bonnie L. Russo  
Job No. 3196191

1 Videotaped Deposition of Hugh Shannon held at:

2  
3  
4  
5  
6  
7 Climaco Wilcox Peca Tarantino & Garofoli, LPA  
8 55 Public Square  
9 Suite 1950  
10 Cleveland, Ohio 44113  
11  
12  
13  
14

15 Pursuant to Notice, when were present on behalf  
16 of the respective parties:  
17  
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## C O N T E N T S

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## EXHIBITS

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(Exhibits retained by Mr. Gallucci.)

P R O C E E D I N G S

THE VIDEOGRAPHER: Good morning.

We are going on the record at 9:02 a.m. on January 24th, 2019.

Please note that the microphones are sensitive and may pick up whispering, private conversations and cellular interference. Please turn off all cell phones or place them away from the microphones as they can interfere with deposition -- with the deposition audio. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is Media Unit No. 1 of the video recorded deposition of Hugh Shannon, taken by counsel for defendant in the matter of In Re: National Prescription Opioid Litigation, filed in the United States District Court for the Northern Division of Ohio, Eastern Division, case No. 17-MD-2804.

This deposition is being held at Climaco, Wilcox, Peca, Tarantino & Garofoli, LPA, located at 55 Public Square, Suite 1950, Cleveland, Ohio.

1                   My name is Daniel Russo from the  
2                   firm Veritext Legal Solutions. I am your  
3                   videographer today. The court reporter is  
4                   Bonnie Russo from the firm Veritext Legal  
5                   Solutions.

6                   Counsel and all present in the room  
7                   and everyone attending remotely will now state  
8                   their appearances and affiliations for the  
9                   record.

10                  MR. CHEFFO: Mark Cheffo from  
11                  Dechert for Purdue defendants.

12                  MS. NEWMARK: Jenna Newmark from  
13                  Dechert for the Purdue defendants.

14                  MR. BORANIAN: Steve Boranian of  
15                  Reed Smith for defendant AmerisourceBerger.

16                  MS. ZERRUSEN: Sandra Zerrusen from  
17                  Jackson Kelly on behalf of AmerisourceBergen.

18                  MR. CARTER: Ed Carter from Jones  
19                  Day for Wal-Mart.

20                  MS. JAMES: Erica James, Tucker  
21                  Ellis, on behalf of Janssen Pharmaceuticals and  
22                  Johnson & Johnson.

23                  MR. GALLUCCI: Frank Gallucci,  
24                  Plevin & Gallucci, on behalf of Cuyahoga  
25                  County.



1 MS. FLEMING: Maria Fleming, Napoli  
2 Shkolnik, on behalf of Cuyahoga County.

3 THE VIDEOGRAPHER: Will anyone  
4 appearing remotely please state their  
5 affiliations for the record as well.

6 MR. GALLUCCI: Is there anybody on  
7 the phone?

8 MR. LUXTON: Yeah. Steve Luxton,  
9 L-U-X-T-O-N, from Morgan Lewis for the Teva  
10 defendants.

11 MR. SQUIRE: Russell Squire, two Ss,  
12 two Ls, from Covington & Burling on behalf of  
13 McKesson.

14 THE VIDEOGRAPHER: Will the court  
15 reporter please swear in the witness.

16  
17 HUGH SHANNON,  
18 being first duly sworn, to tell the truth, the  
19 whole truth and nothing but the truth,  
20 testified as follows:

21  
22 EXAMINATION BY COUNSEL FOR DEFENDANT

23 PURDUE PHARMA L.P.

24 BY MR. CHEFFO:

25 Q. Good morning, sir.

1                   My name is Mark Cheffo.

2           A.       Good morning.

3           Q.       Can you please state your -- your  
4 full name for the record.

5           A.       Hugh Shannon.

6           Q.       And what's your current title?

7           A.       I'm the director of operations at  
8 the Cuyahoga County Medical Examiner's Office.

9           Q.       Okay. And you were deposed last  
10 week; is that right?

11          A.       Correct.

12          Q.       Have you ever been deposed before  
13 that?

14          A.       I have not.

15          Q.       So you understand that today you're  
16 under oath?

17          A.       Yes.

18          Q.       And a few ground rules.

19                   If there's any time that you need a  
20 break, just let us know, and we're happy to do  
21 that. This is not an endurance test.

22                   You'll -- you'll tell us?

23          A.       I will. Thank you.

24          Q.       And also, as I'm sure will happen  
25 from time to time, if anything I ask you you're

1 not clear on, just let me know, and I'll try  
2 and rephrase the question. Okay?

3 A. Very good.

4 Q. Because I want to assume, if you  
5 answered it, you understood it.

6 Fair?

7 A. Understood.

8 Q. And the last thing is I will try my  
9 best not to speak over your -- your answers.  
10 If you'd just make sure you try and let me  
11 finish the question. So this way the court  
12 reporter can get both of our questions and  
13 answers down.

14 Fair?

15 A. Very good.

16 Q. Okay. And I don't want you to tell  
17 me about any conversations you had with your  
18 lawyers.

19 But would you tell me what, if  
20 anything, you did to prepare for the deposition  
21 today?

22 A. Well, I -- I had done a lot for last  
23 week's. So there wasn't a whole lot I felt I  
24 needed to do more than what I had already done  
25 for last week's deposition.

1           Q.     Okay. Did you speak with Dr.  
2     Gleason about his deposition?

3           A.     Dr. --

4           Q.     Gilson.

5           A.     -- Gilson?

6           Q.     Excuse me. I'm sorry.

7           A.     I -- I spoke with him, but it was  
8     about work related. I -- he was out all day  
9     Tuesday. I knew I was going to be out all day  
10    today. And I had administrative meetings  
11    yesterday. So we kind of passed in the hall.  
12    But nothing specific about --

13          Q.     Sure?

14          A.     -- this.

15          Q.     Worth -- work-related issues that  
16    you --

17          A.     Correct.

18          Q.     -- would normally talk to him about?

19          A.     Yes. Correct.

20          Q.     And did you meet with the lawyers at  
21    all before -- before today?

22          A.     We had a brief phone conversation  
23    yesterday afternoon.

24          Q.     And how long was that for?

25          A.     Less than an hour, I think.

1 Q. Okay. And did you meet with or talk  
2 with anyone else about --

3 A. No, I did not.

4 Q. Okay. And did you review any  
5 documents in particular for this deposition?

6 A. For today, no. I think I went over  
7 some of the old -- some old e-mails. But that  
8 was the only thing I think I read.

9 Q. You did that between your last  
10 deposition and today?

11 A. Yes.

12 Q. And what e-mails did you look at?

13 A. I think it was just some old  
14 correspondence from the task force when we were  
15 first starting to kind of put policies,  
16 suggestions in place.

17 Q. And what task force are you  
18 referring to?

19 A. That would be the U.S. attorney's  
20 Opioid Task Force that Steve Dettelbach and  
21 Carole Rendon were running at the time, 2013.

22 Q. Is 2013 when that task force was  
23 first started?

24 A. Yes.

25 Q. And there's another task force that

1       you're apart of; is that right?

2           A.       The -- I assume you're referring to  
3       the Board of Health's opioid --

4           Q.       Yes, sir.

5           A.       -- Opiate Task Force.

6                    That one is primarily attended by  
7       Dr. Gilson. We kind of split the duties up.

8           Q.       But you're generally aware of the --

9           A.       I'm aware of it, yes.

10          Q.       Okay. And when did the Board of  
11       Health task force first start?

12          A.       I believe that was in 2010.

13          Q.       And what is the -- to your  
14       understanding, what is the -- the function or  
15       the mission statement of the Board of Health  
16       task force?

17                   MR. GALLUCCI: Object to form.

18                   THE WITNESS: The Board of Health  
19       started their task force. I believe it was  
20       specifically to address the overprescription of  
21       pain medication, opioids and opiates.

22                   BY MR. CHEFFO:

23          Q.       And -- and what -- do you -- do you  
24       know the name of that -- specific name of the  
25       task force?

1           A.       I believe it just says the opiate  
2 task force.

3           Q.       And it was started in 2010 to  
4 address overprescription of opioid --

5           A.       Prescription opiates, yeah.

6           Q.       And -- and I take it that's -- in  
7 2010 or before, that's when the county and the  
8 Board of Health determined that there was a  
9 concern about prescription opioids?

10           MR. GALLUCCI: Object to form.

11           THE WITNESS: I believe that it was  
12 mainly being driven out of Columbus by the  
13 state. The Board of Health here locally  
14 answers up through the Department of Health at  
15 the state level. And the state had been doing  
16 a lot of work legislatively to address  
17 prescription opiates and how they are being  
18 dispensed.

19           BY MR. CHEFFO:

20           Q.       But the -- Cuyahoga County  
21 participated in that effort in 2010, right?

22           A.       The Board of Health, yes.

23           Q.       And were there other members of  
24 Cuyahoga government that participated?

25           MR. GALLUCCI: Object to form.

1 THE WITNESS: That was before my  
2 time at the medical examiner's office. So I  
3 couldn't speak to that. I know our  
4 participation, through Dr. Gilson, started  
5 sometime in 2012, I believe.

6 BY MR. CHEFFO:

7 Q. Do you know if anyone from Cuyahoga  
8 County law enforcement participated?

9 A. I'm not aware.

10 Q. Do they participate now?

11 A. I believe so, but I don't know for  
12 sure, yeah.

13 Q. What other agencies or departments  
14 of government participate currently in the  
15 Board of Health Opiate Task Force?

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: The ADAMHS Board, so  
18 that Alcohol, Drug, Mental Health Services  
19 Board, participates. I -- I -- I'm sure there  
20 are others. I'm not -- I'm -- again, I'm not  
21 in those meetings. So I don't specifically  
22 know who comes in and comes out.

23 Q. And it's -- it's your recollection  
24 or understanding that this was an effort  
25 started at the state level, after recognizing



1 issues and concerns with prescription opioids,  
2 that they started a task force?

3 Is that fair?

4 MR. GALLUCCI: Object to form.

5 THE WITNESS: My -- that's my  
6 understanding of how the local Board of Health  
7 became involved in creating the task force at  
8 the local level. I can't speak to what the  
9 state was thinking or doing.

10 BY MR. CHEFFO:

11 Q. So let me just ask.

12 So is -- is the -- is the -- the  
13 task force that was created in 2010, is -- was  
14 that created at the local level, or was that an  
15 adjunct to the statewide level?

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: I couldn't say  
18 specifically. I believe that it grew out of  
19 directives coming from the state's Board of  
20 Health.

21 BY MR. CHEFFO:

22 Q. But -- but in -- in the -- in the  
23 Cuyahoga County Board of Health Opioid Task  
24 Force, is that populated by -- and -- and --  
25 and run by the county; or is that run by the

1 state?

2 MR. GALLUCCI: Object to form.

3 THE WITNESS: It's run out of the  
4 county Board of Health.

5 BY MR. CHEFFO:

6 Q. And who is the chairperson?

7 A. It was Vince Caraffi. I believe  
8 that has since changed in the past few months.

9 Q. And -- and what position did Vince  
10 Caraffi hold?

11 A. He was a -- I don't know his exact  
12 title at the Board of Health, but he was at  
13 least one of the chairs of the opiate task  
14 force. But I believe his original duties were  
15 in environmental aspects of -- of the board  
16 of -- Board of Health's operations.

17 Q. Okay. And when we're -- and I just  
18 want to make sure that we're clear.

19 When you're talking now about Mr.  
20 Caraffi and the Board of Health, you're talking  
21 about the Cuyahoga County Board of Health?

22 A. Correct.

23 Q. So in 2010 the Cuyahoga County Board  
24 of Health established an opiate task force.

25 Is that --

1 MR. GALLUCCI: Object --

2 BY MR. CHEFFO:

3 Q. -- your understanding?

4 MR. GALLUCCI: Object to form.

5 THE WITNESS: That's my  
6 understanding, yes.

7 BY MR. CHEFFO:

8 Q. And that was done in order to  
9 address concerns about opioid prescriptions and  
10 its impact on the community back in 2010; is  
11 that right?

12 MR. GALLUCCI: Object to form.

13 THE WITNESS: Again, I'm not as  
14 familiar with the operation of that. It -- it  
15 started before I got there. I know the state  
16 had been doing work legislatively; they had  
17 concerns; and that this task force was one of  
18 the things I think that the state was  
19 encouraging, try to address the problem of  
20 prescription opioids.

21 BY MR. CHEFFO:

22 Q. And when you say "the problem of  
23 prescription opioids," can you be more  
24 specific?

25 A. The overprescribing the -- I mean

1 I'm not entirely sure. Again, if I'm in the  
2 room, I understand these things a lot better  
3 than trying to, you know, go off of what other  
4 people have said and other people have  
5 recollected.

6 But prescription opiates had become  
7 a concern for the state. They were addressing  
8 it legislatively. I'm sure there are a number  
9 of issues that are surrounding  
10 overprescription, overdispensing --

11 Q. Okay.

12 A. -- oversupply.

13 Q. And does the Opioid Task Force today  
14 deal only with prescription opioids, or does it  
15 deal with things like heroin, illicit fentanyl,  
16 carfentanil?

17 A. So --

18 MR. GALLUCCI: Object to form.

19 THE WITNESS: -- the -- the U.S.

20 Attorney's task force was started in 2013 to  
21 specifically address what was an emerging  
22 heroin issue that led to the summit that we had  
23 at the end of 2013 and then subsequently  
24 community action plan.

25 A lot of that overlapped as -- the

1 people who were attending one or both of those  
2 overlapped. The agencies that were involved  
3 overlapped. So there was a lot of overlap  
4 between the two.

5 I believe, again, not having been in  
6 the room at the -- at the Board of Health's  
7 task force, that they tried to stay mainly  
8 focused on prescription opiates and opioids.  
9 But there may have been discussions about other  
10 issues that cropped up subsequent to that  
11 original.

12 BY MR. CHEFFO:

13 Q. Fair enough. And I -- and, you  
14 know -- and I -- it probably goes without  
15 saying because you have a very good lawyer,  
16 but, you know, I'm going to ask you a lot of  
17 questions. Some of them you may have personal  
18 knowledge; some of -- you -- you don't.

19 If you are -- if you're speculating  
20 or guessing, you'll tell us you don't know.  
21 And if you -- you know, if you have  
22 information, then you'll give it us to.

23 Fair?

24 A. Fair.

25 MR. CHEFFO: The reason -- let me

1       just mark this, if I could.

2                   (Deposition Exhibit 1 was marked for  
3       identification.)

4                   BY MR. CHEFFO:

5               Q.       So I just identified this. This is  
6       a -- a more recent. We can go back and see if  
7       there's something earlier, but I just want to  
8       orient you to it.

9                   This is a Cuyahoga County Opiate  
10       Task Force report from 2016.

11                  Do you see that?

12               A.       I do.

13               Q.       And is that the Board of Health  
14       Opiate Task Force we've been talking about?

15                  MR. GALLUCCI: Object to form.

16                  THE WITNESS: It appears to be, yes.

17                  BY MR. CHEFFO:

18               Q.       Okay. And separate from the U.S.  
19       Attorney's task force; is that right?

20               A.       Correct.

21               Q.       And do you -- if you look at the  
22       first page -- or the second page, I guess --

23                  MR. GALLUCCI: Just to be clear,  
24       Mark, are we talking about the cover being the  
25       first page?

1                   MR. CHEFFO: Yeah. Exact -- it's --  
2                   it's got a -- a spoon with -- looks like some  
3                   drug substance there.

4                   BY MR. CHEFFO:

5                   Q. And you could feel free to -- to  
6                   just look through any of this.

7                   But is there -- do you see on the --  
8                   in the -- what -- what I guess would be the  
9                   third page -- they're not numbered -- it's got  
10                  -- on -- on the right-hand column -- "Overview  
11                  of Local Drug-Related Deaths"?

12                  A. I see that.

13                  Q. In looking at -- at any of the  
14                  points in the right-hand column, does this in  
15                  any way refresh your recollect as to whether  
16                  the Board of Health Opiate Task Force is  
17                  focused on just prescriptions, or is it broader  
18                  than that?

19                  MR. GALLUCCI: Object to form.

20                  THE WITNESS: So I don't have any  
21                  direct knowledge because I'm not in the room.  
22                  So refreshing my memory, no. But it appears to  
23                  be obvious that they do talk about other  
24                  opiates, opioids than prescriptions, based on  
25                  what I'm reading.

1 BY MR. CHEFFO:

2 Q. And do you see -- do you see on the  
3 bottom right it says "How did this happen?"

4 A. I see that.

5 Q. And -- and you could see right below  
6 that, sir, it says: "There are several  
7 contributing factors that led to this  
8 epidemic."

9 Do you see that?

10 A. I do.

11 Q. And is it a fair reading that  
12 they're talking about an opioid epidemic in the  
13 community?

14 MR. GALLUCCI: Object to form.

15 THE WITNESS: I believe that's the  
16 intention, yes.

17 BY MR. CHEFFO:

18 Q. And within that section from this  
19 2016 Board of Health task force document, it --  
20 there's a number of bullets. It looks like  
21 there are -- one, two, three, four, five, six,  
22 seven -- eight bullets.

23 Do you see those?

24 A. I do.

25 Q. And those are the -- the



1 contributing factors according to this county's  
2 Opiate Task Force that led to the opioid  
3 epidemic, right?

4 MR. GALLUCCI: Object to form.

5 THE WITNESS: That appears to be the  
6 intention, yes.

7 BY MR. CHEFFO:

8 Q. And have you ever talked about, in  
9 your own either personal or professional work,  
10 the fact that the opioid crisis or opioid  
11 issues, problems in the county are  
12 multifactorial and -- and complicated?

13 MR. GALLUCCI: Object to form.

14 THE WITNESS: Could you -- could  
15 you --

16 MR. CHEFFO: Sure.

17 THE WITNESS: -- repeat that?

18 MR. CHEFFO: Well, let me -- let me  
19 ask a -- a better question.

20 THE WITNESS: Okay.

21 BY MR. CHEFFO:

22 Q. Do -- is it your -- your own belief  
23 that the opioid problem or crisis in Cuyahoga  
24 County is a complicated one that is  
25 multifactorial?

1 MR. GALLUCCI: Object to form.

2 THE WITNESS: So there's no doubt  
3 that it's a evolving situation, which makes  
4 things complicated.

5 I would say overall it's a fairly  
6 simple problem. There was a direct link, based  
7 on information that we had access to and then  
8 later confirmed with our own research at the  
9 Medical Examiner's Office, that most people had  
10 been prescribed opiates; and that, when that  
11 supply ran out due to various reasons -- loss  
12 of insurance, any of the state's crackdowns on  
13 pill mills -- that they turned to other means  
14 and methods to -- to address their own sickness  
15 of addiction.

16 Q. And -- and what data are you relying  
17 on for that -- that belief?

18 A. So we at the Medical Examiner's  
19 Office instituted a poison death review  
20 committee. It was intended to do case reviews  
21 of the fatalities due to, at the time, heroin  
22 overdoses, the deaths that were related to  
23 heroin overdoses, and to try to determine kind  
24 of the factors that led to that death and  
25 possible public policy and intervention points

1 along that continuum of that person's  
2 interactions, either with the county or with  
3 medical or any other interactions that we might  
4 be able to identify with what we had available  
5 to us in the case file.

6 And when that was -- when we had  
7 done those reviews and started to compile and  
8 analyze the data, it showed that about  
9 three-quarters to 80 percent of people who were  
10 dying of heroin overdoses had had a previous  
11 prescription, and most -- most all of those  
12 were prescribed pain pills, opioids, opiates.

13 So essentially about two-thirds of  
14 the people end up being -- who died of a heroin  
15 overdose had had a previous opiate  
16 prescription.

17 Q. So your testimony is two-thirds of  
18 the people who had a heroin overdose had a  
19 previous prescription of opioids?

20 A. That's the general number. I can  
21 get the specifics if I have the reports, but...

22 Q. And I take it you determined that  
23 they had not used heroin prior to getting an  
24 opioid, right?

25 A. The research was that people who had

1       -- that we knew had died of a heroin overdose  
2       had had a previous opioid prescription.

3           Q.     Right.

4                   But wasn't -- you just told me that  
5       your theory was that people took medicines,  
6       right?

7                   Right?

8           A.     Yes.

9           Q.     And they somehow stopped taking  
10       them, either because law enforcement took away  
11       their source or insurance stopped giving them  
12       reimbursement for prescriptions, right?

13          A.     Yes.

14          Q.     And at that time, they were not  
15       using heroin, under your theory, right?

16          A.     That was a general pattern, yes.

17          Q.     Right.

18                   And then they somehow went on a  
19       pathway -- 80 percent of those people went on a  
20       pathway to then become heroin abusers and  
21       ultimately overdose, right?

22          A.     That's the general pattern that we  
23       discovered, yes.

24          Q.     So in order to -- to make sure that  
25       that actually made sense, you would, one, want

1 to know, in fact, whether they actually abused  
2 heroin prior to actually an opioid, right?

3 A. If we could determine it, yes.

4 Q. Did you look for that?

5 A. We did.

6 Q. How far back did -- did your review  
7 go?

8 A. Well, it's changed over time. We  
9 initially did not have access to the OARRS  
10 database. Dr. Gilson had to spend some time  
11 lobbying to get access for coroners and medical  
12 examiners.

13 I believe we received the initial  
14 access middle of 2013 and then started doing  
15 reviews. At the time there was only a two-year  
16 look-back into the prescription histories.

17 So when we started reviewing cases  
18 from 2012, if someone had died say in January  
19 of 2012, we could only see six months back  
20 previous history. Because getting access in  
21 the middle of 2013 meant we could only see back  
22 to the middle of 2011.

23 So as time went on, we were able to  
24 see more and more. And then improvements to --  
25 to OARRS in 2015 and then 2016 that allowed

1 longer look-backs, more history, then we got to  
2 see four then five years back in time, which  
3 provided a more complete prescription history.

4 Q. So when you use the 80 percent  
5 number, is that from -- what -- what years data  
6 is that from?

7 A. It's I think an amalgamation of data  
8 from 2013, '14 and then --

9 Q. Right.  
10 And that was the time when you  
11 only --

12 MR. GALLUCCI: Hold --

13 MR. CHEFFO: Oh, sorry.

14 MR. GALLUCCI: Are you finished  
15 answering?

16 THE WITNESS: Well, I -- I was just  
17 going to say we had most of 2015 done. 2016  
18 hit. It was actually the worst year that we  
19 had had in all. That's when we had a complete  
20 doubling of the total number of drug deaths,  
21 and we got overwhelmed.

22 So it kind of delayed our ability to  
23 do that kind of in-depth analysis any longer.  
24 We are about ready to -- to put out '15, '16  
25 and '17.

1 MR. CHEFFO: Okay.

2 THE WITNESS: -- data.

3 BY MR. CHEFFO:

4 Q. I want to talk about this 80 percent  
5 statistic.

6 I understood that that largely came  
7 from a review that you did in 2013 data, '14  
8 data, right?

9 That's what you just told me?

10 A. Correct. It matched also with data  
11 that other government agencies, the CDC and so  
12 forth had --

13 Q. So and at --

14 A. -- seen.

15 Q. -- to that point, you only had a  
16 look-back of about six months?

17 A. Well, again, it changed over time.  
18 So we only had a six-month look-back at people  
19 who had died in January of 2012. We had an  
20 18-month look-back in people who had died in  
21 January of 2013.

22 Q. Okay. So somewhere between six  
23 months and -- and 18 months, if they had an  
24 overdose and -- you say a look-back.

25 That means you checked OARRS, right?

1           A.       Correct.

2           Q.       And you found that there was an  
3       opioid prescription -- a lawful opioid  
4       prescription, right?

5           A.       Correct.

6           Q.       And just to be clear, OARRS tracks  
7       controlled substances, not just opioids, right?

8           A.       Correct.

9           Q.       And when you say there was  
10       80 percent of people who used heroin who used  
11       opioids, that's actually not right, even on  
12       your own data, is it?

13                   MR. GALLUCCI:   Object to form.

14                   THE WITNESS:   So what I had said was  
15       is that 80 percent of the people had an OARRS  
16       report and that about two-thirds of the people  
17       who died of heroin overdoses ended up having a  
18       prescribed opiate.

19                   BY MR. CHEFFO:

20           Q.       I thought it was about 65 percent of  
21       the people had an OARRS report, and then there  
22       was about 80-something percent of those had an  
23       opioid prescription.

24           A.       It's --

25                   MR. GALLUCCI:   Object to form.



1 THE WITNESS: It's about 80 percent  
2 had an OARRS report. And of those, 75 percent,  
3 give or take percentage points, had opiates.  
4 So when you do the calculation, it ends up  
5 being about two-thirds, give or take.

6 Depending on which year you're  
7 looking at, it fluctuates a little bit.

8 MR. CHEFFO: Okay.

9 THE WITNESS: But it's held fairly  
10 steady.

11 BY MR. CHEFFO:

12 Q. And if somebody had an overdose, and  
13 there was an OARRS report, and it was for --  
14 and they had an OARRS report for having a  
15 prescription, did you make a determination  
16 that -- if it was 6 or 18 months, that they had  
17 a prescription, they became addicted, became an  
18 abuser, lost their insurance, lost their  
19 ability, and then that led them directly to  
20 heroin?

21 Is that what your -- your study did?

22 MR. GALLUCCI: Object to form.

23 THE WITNESS: So our study reviewed  
24 what information we were able to collect during  
25 our investigations: -- family, medical

1 records, whatnot -- and tried to determine what  
2 the path was that led to that person's death.

3 MR. CHEFFO: Right.

4 THE WITNESS: That's what we were  
5 tasked with.

6 BY MR. CHEFFO:

7 Q. Would it surprise you if Dr. Gilson  
8 and others have testified that there was no way  
9 you could draw a causal connection using that  
10 data?

11 MR. GALLUCCI: Object to form.

12 THE WITNESS: It would surprise me  
13 if they made that an absolute statement, yes.

14 BY MR. CHEFFO:

15 Q. Okay. Would it surprise you if they  
16 said that there is a causal connection; that  
17 was the point of their look-back data study?

18 MR. GALLUCCI: Object to form.

19 THE WITNESS: It wouldn't surprise  
20 me, no.

21 BY MR. CHEFFO:

22 Q. Because that would be true, right?

23 A. So --

24 MR. GALLUCCI: Object to form.

25 THE WITNESS: -- we reviewed

1       hundreds of cases. Some of the investigations  
2       were better informed by families. People who  
3       don't have families, there's less history. So  
4       it's a mixed bag of -- of the entire spectrum.

5               BY MR. CHEFFO:

6               Q.     Okay. But --

7               A.     And we've hundreds of cases to  
8       review.

9               Q.     So -- so how many of those cases did  
10       you find with a level of -- of comfort and  
11       specificity that meets your theory, right?

12               How many of them did you see that  
13       you actually found someone who was in OARRS,  
14       with an overdose, who never had an abuse  
15       history, who never used heroin -- you can  
16       determine that -- who was never issued  
17       Naloxone, never in the -- in the -- had a drug  
18       treatment problem, and then went on from  
19       lawfully getting a prescription to becoming a  
20       heroin addict and overdosing?

21               How many of those do you -- and if  
22       -- and if you have those, I -- I'd like to  
23       figure out where we can identify those specific  
24       folks.

25               MR. GALLUCCI: Object to form.

1 THE WITNESS: So you threw a lot in  
2 there.

3 BY MR. CHEFFO:

4 Q. Right.

5 Well, because you --

6 A. So --

7 Q. -- you've told me, sir, that -- that  
8 there's an 80 percent correlation or causation  
9 between people who took the prescription and --  
10 it's your data. You've now told us that, with  
11 some level of -- of certainty, apparently,  
12 80 percent of people who took prescriptions  
13 went on to become heroin addicts and overdose.

14 So I want to drill down on that.

15 MR. GALLUCCI: Object to form.

16 Were you finished answering the last  
17 question?

18 THE WITNESS: Not really. But  
19 that's fine.

20 I -- so I want to be clear so that  
21 I'm answering the question that you actually --

22 MR. CHEFFO: Uh-huh.

23 THE WITNESS: -- are asking.

24 You keep reversing that 80 percent.

25 So what I have said, and what the data has

1 shown, is -- is that, of the people who had  
2 died of a heroin overdose, 80 percent had a  
3 OARRS report on file, on record, that we could  
4 see. Of those, a certain percentage had  
5 opiates prescribed to them. It end -- ends up  
6 being about two-thirds of the people who died  
7 of a heroin overdose also had a previous  
8 opiate, opioid prescription.

9 That said, the last string that you  
10 threw in there had a lot of elements to it,  
11 some of which may have applied, some of which  
12 may not.

13 Getting access to Naloxone is not  
14 mutually exclusive for someone who is  
15 prescribed opiates. They may be abusing those  
16 prescribed opiates. And Naloxone will work to  
17 reverse a prescription opiate overdose as well  
18 as a heroin overdose.

19 So that would not be a determining  
20 factor. And that was part of your kind of list  
21 of --

22 BY MR. CHEFFO:

23 Q. So -- so tell me what the 80 percent  
24 does then that you -- or the -- or the -- the  
25 two-thirds figure.

1                   What is that?

2                   Is that -- is -- is -- is what  
3           you're telling me is what you did is you  
4           identified the number of people and -- who  
5           overdosed, and of those there was a certain  
6           percentage within the look-back period -- that  
7           could be either 6 or 12 months or perhaps even  
8           later than that that -- that, when you checked  
9           OARRS, they had a prescription for an opioid.

10                  MR. GALLUCCI: Object.

11                  BY MR. CHEFFO:

12                  Q.       That -- that's what the data did,  
13           right?

14                  MR. GALLUCCI: Object to form.

15                  THE WITNESS: That's what the data  
16           did in 2013.

17                  2014 it extended that look back to  
18           two years. Improvements were made to the  
19           system. At 2015 and 2016 we were able to see  
20           for five years back.

21                  So we're able to establish patterns  
22           with more data that showed that there -- and  
23           that -- and that the number of people who were  
24           dying from illicit opiates were still also  
25           getting prescribed opiates in their OARRS

1 history prior to their death.

2 BY MR. CHEFFO:

3 Q. Right.

4 And you -- you didn't know why they  
5 were prescribed the opioids, right?

6 A. Not necessarily in all cases, no.

7 Q. You didn't know whether they were  
8 abusing them, did you?

9 A. Not in all cases, no.

10 Q. You didn't talk to any doctors as to  
11 anything about the patient or the purpose of  
12 the prescription, did you?

13 A. I did not.

14 Q. Did anybody?

15 A. But we had medical records, so...

16 Q. Did anyone talk to the doctors?

17 A. I -- I don't know if Dr. Gilson had  
18 those discussions.

19 Q. Let me ask you this: Are you -- are  
20 -- do you hold yourself out as an expert in --  
21 in statistics?

22 A. No.

23 Q. Are you an expert in epidemiology?

24 A. No.

25 Q. Are you an expert in drug addiction?

1           A.       No.

2           Q.       Are you an expert in -- did you have  
3 any medical degree?

4           A.       No.

5           Q.       Do you have any -- any medical  
6 background?

7           A.       I -- I'm not a doctor, and I'm not a  
8 scientist. I didn't know I - this was expert  
9 testimony. So I'm not holding myself out to be  
10 an expert at all.

11                   I know more about this than I ever  
12 wanted to. Over the last seven years, having  
13 lived and breathed this epidemic, I've learned  
14 quite a bit. And it falls to me to make sure  
15 that the records are kept, that they're  
16 available.

17                   We tried to facilitate as best we  
18 could partnerships within the community to be  
19 able to address the issues that stemmed from  
20 this, to try to marshall resources, to share  
21 information and data as best we could so that  
22 everybody was operating with some basic  
23 fundamental foundation of information.

24           Q.       Okay. And just -- I agree with you.  
25 You're -- you're not an expert. We're here for



1 a fact deposition.

2 But is that clear?

3 You're -- you're not testifying in  
4 any expert capacity, right?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: I -- no. I didn't  
7 claim --

8 BY MR. CHEFFO:

9 Q. And --

10 A. -- I was. No.

11 Q. You don't hold yourself out as an  
12 expert in any of these areas, do you?

13 A. No.

14 MR. CHEFFO: Okay. Let's mark this.

15 (Deposition Exhibit 2 was marked for  
16 identification.)

17 BY MR. CHEFFO:

18 Q. You see that e-mail string?

19 A. I do.

20 Q. Is that one of the e-mails that you  
21 reviewed prior to the deposition?

22 A. It is not.

23 Q. Okay. And I'm -- I have a few  
24 questions. But if you need to, obviously,  
25 review it or refresh your recollection.

1                   But you see this is from 2016, and  
2           it's from you to various other folks in the  
3           county?

4           A.       Yes.

5           Q.       And --

6                   MR. GALLUCCI: Do you want to take a  
7           minute to review it?

8                   THE WITNESS: That's fine.

9                   BY MR. CHEFFO:

10          Q.       Are you ready, sir?

11          A.       Uh-huh.

12          Q.       Thanks.

13                   And -- and Mr. Gallucci's point is  
14          fair. I mean sometimes I'll show you a very  
15          large document; I'll have a question or two.  
16          But on something like this, you know, obviously  
17          if you need to review, I -- it's not a memory  
18          test.

19                   But do you -- does this -- well,  
20          first, do you remember this -- this exchange or  
21          this topic?

22          A.       Not specifically.

23          Q.       Okay. But you know all the people  
24          who are listed on the document, right?

25          A.       I do, except for Angela Conover, who

1 starts the string.

2 Q. Okay. And you see it says that  
3 there is no empirical evidence to provide such  
4 a precise correlation we can say that  
5 percentage of deaths had legitimate prescribed  
6 opioids previous to death, right?

7 A. I see that.

8 Q. And that's -- that's what we've been  
9 talking about, right, that the data is meant to  
10 just look at whether there were prescriptions  
11 prior to death?

12 That -- that's what the -- the  
13 county was looking at, right?

14 MR. GALLUCCI: Object to form.

15 THE WITNESS: Yeah. I don't -- I  
16 don't think that had -- I don't think we had  
17 any specific percentage of -- of cases that we  
18 could -- that we could say that with any  
19 specificity. Right.

20 BY MR. CHEFFO:

21 Q. Right.

22 And you understand that correlation  
23 is even less of a standard than -- than  
24 causation, right?

25 MR. GALLUCCI: Object to form.

1 THE WITNESS: I suppose so. I...

2 BY MR. CHEFFO:

3 Q. Right.

4 And -- and here you're saying, based  
5 on the data and the OARRS look-back, what you  
6 can do is you can find out the number of people  
7 who are in the OARRS database and -- and use  
8 that for whatever purpose you deem appropriate,  
9 but you can't correlate the fact that someone  
10 had an opioid prescription in the OARRS  
11 database to ultimately weather that led them to  
12 become an abuser and a heroin addict, right,  
13 because you just didn't have enough information  
14 to make that correlation.

15 A. Not at that time, no.

16 Q. Do you have that now, that -- that  
17 type of information?

18 A. I'm -- I'm not entirely sure we  
19 don't. We hadn't been looking specifically at  
20 that. We can go back and try to do that. We  
21 have other people who are now engaged in the  
22 research and may have access to information  
23 like that.

24 I can say that, from a lot of the  
25 cases that came through our office, as well as

1 speaking to parents, relatives of people that  
2 they had lost, they had conveyed that sentiment  
3 to us is that that was the -- that was the  
4 inception of their addiction.

5 Q. Okay.

6 A. But yeah, I couldn't give you a  
7 percentage, no --

8 Q. Okay.

9 A. -- at this time.

10 MR. CHEFFO: I'll actually move to  
11 strike.

12 BY MR. CHEFFO:

13 Q. Do you remember my -- the question I  
14 asked you, sir?

15 A. You can go ahead --

16 MR. GALLUCCI: He's asking -- he's  
17 answering your question.

18 MR. CHEFFO: Could you read back the  
19 question I asked.

20 MR. GALLUCCI: And I would say you  
21 probably need to look at even the one before.  
22 Because you had asked one, then you asked him  
23 further clarification. So if you want to read  
24 them back, we can.

25 BY MR. CHEFFO:

1           Q.     Okay. Well, I -- I -- I -- you --  
2     you -- you have some anecdotal information  
3     you've told us about, right, from families?

4           A.     Correct.

5           Q.     And I'm sure that that's a difficult  
6     situation, and they are in a very difficult  
7     time, and -- and you credit what they say,  
8     right?

9           A.     Correct.

10          Q.     No one's questioning that.  
11                 My -- my question was more focused  
12     on data.

13                 And in 2016 you indicated that  
14     you -- you didn't have a level of information  
15     or data to perform any correlation between any  
16     OARRS reports and ultimate causation. And then  
17     I -- I think I asked you if you were aware of  
18     any after 2016.

19                 Do you recall that?

20          A.     Yes.

21          Q.     And -- and that's what I'm -- just  
22     want to make sure.

23                 Are you, as you sit here today,  
24     aware of any actual data that's been performed  
25     by your department or others after 2016 that

1 shows a correlation or causation between actual  
2 OARRS data or other data that shows a linear  
3 causal chain between someone using an opioid  
4 and heroin overdose?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: I believe I had said  
7 that, that we do not have a specific percentage  
8 that we can point to, no.

9 BY MR. CHEFFO:

10 Q. And -- and the same would be true  
11 for any opioid, right, not just heroin?

12 A. You mean --

13 Q. Fentanyl --

14 A. -- like fentanyl --

15 Q. -- carfentanil --

16 A. -- carfentanil --

17 Q. -- synthetic fentanyl, oxycodone,  
18 hydrocodone.

19 A. Well, hydrocodone, oxycodone are  
20 prescribed opioids. So we would be able to  
21 have a direct link if someone had died because  
22 of an overdose of their prescribed opioid  
23 medication.

24 But no. With respect to the illicit  
25 opioids like fentanyl, carfentanil and the

1       analogs, no. We wouldn't have any more  
2       specific information on those either.

3           Q.       But even there you -- you -- you've  
4       heard the term "diverted," right?

5           A.       Correct.

6           Q.       And -- and opioids is a broad term,  
7       right?

8                   Some -- sometimes imprecise, right?

9           MR. GALLUCCI: Object to form.

10          THE WITNESS: Correct.

11          BY MR. CHEFFO:

12           Q.       I mean because you have things like  
13       heroin and illicit fentanyl that have no  
14       legitimate medical purpose, right?

15           MR. GALLUCCI: Object to form.

16          THE WITNESS: Well, I'm not a drug  
17       expert or a doctor. But I believe fentanyl  
18       does have medical --

19           MR. CHEFFO: Yeah.

20          THE WITNESS: -- efficacy.

21          BY MR. CHEFFO:

22           Q.       That's why I said "illicit  
23       fentanyl."

24           A.       Yeah. Illicit fentanyl, no.  
25       Probably.



1 Q. Right.

2 Like, you know, something that's  
3 made in a lab in Mexico or China, that's not a  
4 legitimate medical use, right?

5 A. I -- correct.

6 MR. GALLUCCI: Object to form.

7 BY MR. CHEFFO:

8 Q. And you're also aware, though,  
9 that -- that there are opioids like fentanyl  
10 that are manufactured pursuant to FDA guidance  
11 by pharma companies, as well as oxycodone and  
12 hydrocodone, that, when used appropriately and  
13 lawfully, they have a legitimate medical  
14 purpose, right?

15 MR. GALLUCCI: Object to form.

16 THE WITNESS: Correct.

17 BY MR. CHEFFO:

18 Q. And then there are situations where  
19 someone could actually have what would  
20 otherwise have been a lawfully manufactured  
21 product, but they divert it or use it in an  
22 improper illegal way, right?

23 Like if -- if they buy it on the  
24 street, or if they take it out of somebody's  
25 medicine cabinet and use it improperly.

1 MR. GALLUCCI: Object to form.

2 BY MR. CHEFFO:

3 Q. Right?

4 A. Correct.

5 Q. So when you -- and I'm -- I'm trying  
6 to just follow up to make sure I understand  
7 your testimony.

8 If somebody has -- in -- in a  
9 toxicology screening for an overdose, if they  
10 have let's say hydrocodone or oxycodone in  
11 their blood, or other tissue, I suppose, where  
12 they do a tox screening from, that doesn't  
13 necessarily mean that they received a lawful  
14 prescription, does it?

15 A. That fact alone does not, no.

16 Q. Okay.

17 A. However we collect, again, OARRS  
18 information. So we're aware of prescriptions.  
19 There are prescription bottles at the scene  
20 with the doctor's name with pill counts. We  
21 keep information on all of those things.

22 Q. Right.

23 So in a situation where someone had  
24 multiple lawful prescriptions that was in  
25 OARRS, they had a prescription bottle next to

1       them that had their name on it, and you did a  
2       tox screening, and there was an elevation, and  
3       the medical examiner determined that was the  
4       cause of death, that would be one that would be  
5       something that could be tracked from a lawful  
6       prescription to a cause of death, right?

7           A.       That is correct.

8           Q.       And do you have any idea of what  
9       percentage of those types of connections to  
10      prescriptions have been determined in the last  
11      two or three years --

12                   MR. GALLUCCI:   Object --

13                   BY MR. CHEFFO:

14           Q.       -- in connection with overdose  
15      deaths in Cuyahoga County?

16                   MR. GALLUCCI:   Object to form.

17                   THE WITNESS:   Deaths by prescribed  
18      opiates?

19                   BY MR. CHEFFO:

20           Q.       Uh-huh.

21           A.       Off the top of my head, no.   It's a  
22      few hundred.   But I would have to look at  
23      the -- at the data specifically.

24           Q.       What would you look at to make that  
25      determination?

1 A. Well, we track --

2 Q. Well, what --

3 A. -- on --

4 Q. -- what data?

5 A. We track on a year-to-year basis the  
6 causes -- the various causes of death involving  
7 what drugs.

8 Q. Isn't -- I mean in the last few  
9 years, isn't it undisputed that the major  
10 driver of overdose deaths from opioids is  
11 heroin and illegal fentanyl?

12 MR. GALLUCCI: Object to form.

13 THE WITNESS: Fentanyl for sure.

14 BY MR. CHEFFO:

15 Q. And is that prescribed fentanyl, or  
16 is it synthetic street fentanyl?

17 A. It's --

18 MR. GALLUCCI: Object to form.

19 THE WITNESS: -- basically illicit  
20 fentanyl, yes.

21 BY MR. CHEFFO:

22 Q. What percentage of the fentanyl  
23 overdose are actually tracked, you know, using  
24 the type of investigative work that you've just  
25 talked about -- OARRS, on-site review, talking

1 to family -- what percentage of the fentanyl  
2 overdoses in the last few years are from  
3 patients who received lawful prescriptions and  
4 then went on to overdose using them?

5 MR. GALLUCCI: Object --

6 BY MR. CHEFFO:

7 Q. Is it very small?

8 MR. GALLUCCI: Object to form.

9 THE WITNESS: Again, we haven't  
10 completed the analysis on that data yet. It's  
11 underway. So I couldn't answer with  
12 specificity, no.

13 Q. You're looking at that right now?

14 A. Yes.

15 Q. And -- and specifically to --

16 A. Our office is.

17 Q. To try and find out how many  
18 overdose deaths where there's fentanyl are  
19 directly related to a lawful prescription?

20 A. Correct.

21 Q. And what are you doing to -- to --  
22 to identify those prescriptions?

23 A. We're using the OARRS database.

24 We did do a brief look at a subset  
25 back in 2017, February. There were about 60

1 deaths that month. It was the worst month that  
2 Cuyahoga County's experienced.

3 And they did a quick look at that  
4 time. And the numbers had mirrored what we had  
5 previously seen in the 2013, '14 data.

6 But again, we're compiling and  
7 analyzing now to release that later this year.

8 Q. Do you have any idea what the  
9 numbers look like?

10 A. I don't. I'm not doing all the  
11 analysis myself, so...

12 Q. And the -- and you would agree, even  
13 if someone has an OARRS entry, that could be --  
14 could still be a -- a prescription that was  
15 prescribed improperly?

16 MR. GALLUCCI: Object to form.

17 BY MR. CHEFFO:

18 Q. Do you understand my question?

19 A. Prescribed improperly?

20 Q. Well, Dr. Gilson and others have  
21 talked about things like doctor shopping or  
22 pill mills.

23 Are you familiar with those two  
24 terms?

25 A. I am.

1 Q. Right.

2 So doctor shopping is when someone  
3 goes to multiple doctors, right, in order to  
4 try to get prescriptions without necessarily  
5 telling the other doctor that they're receiving  
6 a -- a coordinate prescription, right?

7 MR. GALLUCCI: Object to form.

8 THE WITNESS: Correct.

9 BY MR. CHEFFO:

10 Q. That's one of the reasons why OARRS  
11 was established, right?

12 MR. GALLUCCI: Object to form.

13 THE WITNESS: I believe that's one  
14 of the reasons, yes.

15 BY MR. CHEFFO:

16 Q. And in order -- do you look at, in  
17 your analysis, and are you going to be looking  
18 at your analysis, whether there was doctor  
19 shopping?

20 A. Yes.

21 Q. And what about pill mills?

22 A. I'm not sure that we have a -- a way  
23 of knowing whether certain prescribing entity  
24 is a -- what law enforcement would call a pill  
25 mill.

1 Q. Right.

2 But -- but does -- law enforcement  
3 knows, right, because they prosecute those  
4 people?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: I believe they do when  
7 they can, yeah.

8 BY MR. CHEFFO:

9 Q. Right.

10 So have you -- and is it the  
11 intention to go and ask them for all the  
12 identified prosecuted pill mills so you can  
13 then put that into your analysis?

14 A. Law enforcement does have a piece  
15 and a role to play in the analysis. I would  
16 have to check to see what all pieces are being  
17 asked from them.

18 Q. And are you intending or the  
19 department intending to talk to any of the  
20 doctors as to why the prescriptions were  
21 written?

22 A. So that's really up to the forensic  
23 pathologist who are investigating the death,  
24 whether they feel that the medical records they  
25 already have are sufficient and whether a



1 face-to-face or telephone discussion is  
2 required.

3 Q. What happens if someone had a lawful  
4 prescription for fentanyl, let's say, and then  
5 they went out and also then bought street  
6 fentanyl and were abusing that; would that be  
7 classified as a -- a prescription  
8 fentanyl-related death?

9 MR. GALLUCCI: Object to form.

10 THE WITNESS: Classified as in --

11 BY MR. CHEFFO:

12 Q. Your statistics.

13 A. -- the death certificate or --

14 Q. In your -- your -- your report that  
15 you're doing.

16 MR. GALLUCCI: Same objection.

17 THE WITNESS: Unfortunately, I don't  
18 believe we would be able to know with any  
19 certainty. Toxicology doesn't -- doesn't  
20 differentiate. Fentanyl is fentanyl.

21 BY MR. CHEFFO:

22 Q. Right.

23 So you can't -- you can't really  
24 tell, if someone has fentanyl in their system,  
25 whether it's illicit fentanyl manufactured

1        somewhere in China, Mexico or somewhere else,  
2        or whether it's lawful fentanyl, right?

3            A.        Correct. We would have to rely on  
4        other pieces of information to make those  
5        determinations.

6            I will say, having reviewed OARRS  
7        over the years, there are not -- there are not  
8        a significant number of fentanyl prescriptions.  
9        So I don't think it comes up all that often.

10          Q.        So it's very rare that someone would  
11        actually have prescription fentanyl and  
12        overdose on prescription fentanyl?

13          A.        It's happened in the past.

14          Q.        Sure.

15                    But what -- what percentage?

16          A.        But --

17                    MR. GALLUCCI: Please let him  
18        finish --

19                    MR. CHEFFO: Sorry.

20                    MR. GALLUCCI: -- his answer.

21                    THE WITNESS: It's happened in the  
22        past. I would say that it is handfuls in a  
23        year, at least going back to the numbers we  
24        were talking about, 2006 and on.

25                    BY MR. CHEFFO:

1 Q. Handfuls, less than 10 percent?

2 A. Percentage-wise I'm -- I would have  
3 to -- yeah. Probably 10 percent or less.

4 Q. Would the same be true for  
5 prescription oxycodone?

6 A. No. Prescription oxycodone was much  
7 more of a -- a factor in opioid deaths  
8 throughout the years, really up until I think  
9 2016.

10 Q. Is that in alone or in combination  
11 with other drugs?

12 A. It would be all deaths related to  
13 oxycodone. So there may have been other drugs  
14 involved.

15 Q. Could -- so if one was -- had  
16 oxycodone, fentanyl and heroin in their system,  
17 that would be classified as related to  
18 oxycodone?

19 A. It would be classified as related to  
20 all. So the categories, when we use the charts  
21 and we try to make this clear, is that you --  
22 you can't add oxycodone plus heroin plus  
23 fentanyl and get total drugs deaths.

24 It'll be all drugs that involve  
25 fentanyl, all drug -- all -- all overdoses that

1       involve fentanyl, all overdoses that involve  
2       heroin, all that are related specifically to  
3       prescription drugs.

4               Now, as we got more sophisticated  
5       in -- in our look-backs, we did try to parse it  
6       out so that we could tell who died just from  
7       opioid -- prescription opioids, who just died  
8       from fentanyl, fentanyl in combination. We're  
9       having issues with fentanyl-laced cocaine now.

10              So the combinations get more and  
11       more complicated. It takes us longer and  
12       longer to analyze and parse out the data in  
13       appropriate categories.

14              Q.       Okay. Well, and thank you. That --  
15       that's helpful.

16              So let me just ask you then about --  
17       so if you wanted to answer that question,  
18       right, again, it's not a memory test. You  
19       know, I'm not asking you exact numbers in 2015.

20              But if you wanted to, you said --  
21       strike that.

22              You said you -- the -- the system  
23       and the look-back has become more  
24       sophisticated, and there's an effort to try and  
25       identify if there is a single drug that is the

1       cause, right?

2           A.       When we get a cause of death, we  
3       often have multidrug combinations. Coming up  
4       with all the combination possibilities is  
5       getting more and more difficult as you have  
6       more and more drugs being put into the supply  
7       on the street.

8           And so yes, it's -- we can try -- we  
9       can identify when someone dies and they only  
10      have a prescription opiate in their system or  
11      if they only have heroin in their system.

12           Again, once you start adding up all  
13      the possible combinations that exist, it -- it  
14      gets -- it takes more time to analyze that.

15           Q.       Okay. So if -- I take it there's a  
16      database that, if you wanted to run, let's say,  
17      for 2016 and say, "I'd like the printout of all  
18      of the deaths where there's only one drug,  
19      fentanyl," you could do that, right?

20           A.       Correct.

21           Q.       And oxycodone, you could do that?

22           A.       Correct.

23           Q.       And then you could basically query  
24      the system to say, "I'd like the data where  
25      there are two drugs in the system," right?

1           A.     You can.

2           Q.     And then you could probably do  
3 something four or more, right, and capture  
4 those, right?

5           A.     Correct.

6           Q.     And then that would be -- and you  
7 could print out, if you wanted to, a -- kind of  
8 a bar chart, right, saying, "Here's" -- you  
9 know, like you've done in some of your other  
10 data, right?

11                   You can basically say, "Here is the  
12 chart that" -- or the -- the bar graph that  
13 says -- here's oxycodone only, fentanyl only,  
14 heroin only, two or more, right? You could do  
15 all that in a -- and -- and display it  
16 graphically, if you -- if you wanted to.

17          A.     Eventually, yes.

18          Q.     And -- and has that been done?

19          A.     That's part of what's being done for  
20 this new release of -- of data for the '15, '16  
21 and '17 cases. I believe we had a breakdown of  
22 the 2015 cases that we produced something like  
23 that in a report that's on our web site.

24                   I can't remember if we completed it  
25 for 2016 or not. We may have. So there might

1 be data in reports for 2015 and 2016 that have  
2 that data in it.

3 Q. And -- and -- and the -- the reports  
4 that have been generated, are those reports  
5 that identify whether they are from lawful  
6 prescriptions; or are they reports that only  
7 identify, for example, a medicine that can be  
8 lawful, oxycodone, but don't differentiate  
9 whether someone got that through diversion  
10 or -- or got it through a prescription?

11 A. I don't believe those reports  
12 distinguish that.

13 Q. So even if it said it's only  
14 hydrocodone or only oxycodone, all that report  
15 would mean was that the person had that in  
16 their system, right?

17 A. That it contributed to their death.

18 Q. Right.

19 It's not a -- it's not a -- an  
20 attempt or an effort to indicate that they had  
21 received their oxycodone or hydrocodone or any  
22 other lawful medicine from a doctor, and that  
23 was the cause of death, right?

24 MR. GALLUCCI: Object to form.

25 THE WITNESS: I don't believe that

1       it differentiates in those reports. It's not  
2       that we couldn't. It's just a matter of having  
3       enough time to do the analysis.

4               BY MR. CHEFFO:

5           Q.     You --

6           A.     It requires a deeper dive into the  
7       data that we have. And again, some cases we've  
8       better information than others.

9           Q.     Sure.

10          So -- but if -- if the department  
11       wanted to and determined that it was something  
12       that was appropriate, it could actually try to  
13       do just that, right, try to say which are  
14       the -- which are the overdose deaths that are  
15       directly related to a prescription drug, right?

16          And they could look at the tox  
17       studies; they could look at the investigator  
18       studies; they could look at medical records,  
19       right?

20          They have an ability to talk to  
21       doctors and family members?

22       A.     Correct.

23       Q.     Right?

24          So it could -- it could, one by one,  
25       say, "Okay. This person had oxycodone in their



1 system. We want to do a look-back and find out  
2 if it ultimately was related to a prescription  
3 medicine," right?

4 A. We could, yes.

5 Q. And you could actually do that for  
6 heroin or fentanyl as well, right?

7 A. Yes.

8 Q. I mean in other words, you could say  
9 this person is a -- has a fentanyl overdose,  
10 right?

11 Let -- strike that.

12 Let's take heroin because it can't  
13 be legal or illegal.

14 A. Well, let's not take heroin. But  
15 yes. Go ahead.

16 Q. Yes. Thank -- agree with that.

17 You know, if there was a heroin  
18 overdose, you could, using the data and  
19 information you have, look back to determine  
20 whether there was actually any connection to  
21 any lawful prescription, right?

22 MR. GALLUCCI: Object to form.

23 THE WITNESS: I believe so, yes.

24 BY MR. CHEFFO:

25 Q. And -- and you would do that by a

1           number of ways, right?

2           A.       Correct.

3           Q.       You look at OARRS?

4           A.       Yes.

5           Q.       You would look at medical records?

6           A.       Correct.

7           Q.       You'd look at investigator reports?

8           A.       Yes.

9           Q.       Your -- your own investigators,  
10          right?

11          A.       Ours and if there are any police  
12          reports as well.

13          Q.       Any police.

14                  You might access jail records or  
15          other public health or public treatment  
16          records, right?

17          A.       Correct.

18          Q.       And you -- you could talk to the  
19          doctor, right?

20          A.       We could, yes.

21          Q.       If there was a doctor, right?

22          A.       Yes.

23          Q.       And -- and by doing that, you would,  
24          perhaps not in all cases, but in many cases be  
25          able to determine whether there really was any

1 connection between a prescription medicine or  
2 -- or even any prescription medicine in the  
3 chain of events prior to a time that a person  
4 died, right?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: I believe so, yes.

7 MR. CHEFFO: Right.

8 THE WITNESS: And I believe that was  
9 the intent -- the original intent of the death  
10 review was to try to make those determinations  
11 of places where we could intervene. Pamphlets  
12 in a doctor's office about the dangers of  
13 opioids regardless of their source, as an  
14 example. Or letters to people coming out of  
15 treatment, you know, "Beware of going back to  
16 your old habits," whether it was taking heroin  
17 or abusing prescription pills or whatever else.

18 Q. Right.

19 And because there are -- there are  
20 some people who have addictive personalities  
21 who abuse certain types of alcohol or drugs and  
22 then they progress to abusing more serious  
23 drugs, right?

24 MR. GALLUCCI: Object to form.

25 THE WITNESS: So again, I'm not

1 claiming to be an expert in addiction  
2 treatment. I don't believe it's a personality  
3 disorder. I believe it's a physiological one,  
4 but...

5 BY MR. CHEFFO:

6 Q. And I apologize.

7 A. Yes. I -- yes.

8 Q. I didn't mean to say "personality."

9 A. No. It --

10 Q. If I said that, I didn't mean to. I  
11 didn't know that I used those words. But if --  
12 thank you for --

13 A. I just want to clarify.

14 Q. -- the clarification.

15 A. Sure.

16 Q. Yeah.

17 MR. GALLUCCI: Mark -- Mr. Cheffo,  
18 we've been --

19 MR. CHEFFO: Yeah.

20 MR. GALLUCCI: -- going about an  
21 hour.

22 MR. CHEFFO: Oh, sure.

23 MR. GALLUCCI: Would now be an --

24 MR. CHEFFO: Absolutely.

25 MR. GALLUCCI: Okay.

1 MR. CHEFFO: Take a break.

2 MR. GALLUCCI: Yes. About five  
3 minutes?

4 MR. CHEFFO: Yes.

5 THE VIDEOGRAPHER: We are going off  
6 the record.

7 This is the end of Media Unit No. 1.

8 The time is 10:02.

9 (A short recess was taken.)

10 THE VIDEOGRAPHER: We are going back  
11 on the record.

12 This is the start of Media Unit No.  
13 2.

14 The time is 10:14.

15 You may proceed, Counsel.

16 MR. CHEFFO: Thanks.

17 BY MR. CHEFFO:

18 Q. I'm going to --

19 MR. GALLUCCI: Mr. Cheffo, before I  
20 think somebody wanted to go on the record.

21 MR. CHEFFO: Oh, sure.

22 Is there some --

23 MR. GALLUCCI: Was there somebody  
24 else who joined the deposition?

25 Sorry.

1 MR. CHEFFO: No. Thanks, Frank.

2 MS. HARTMAN: Yeah. Ruth Hartman,  
3 Baker Hostetler, on behalf of the Endo  
4 defendants.

5 MR. GALLUCCI: And I would just like  
6 to note that plaintiffs have a continuing  
7 objection with regards to the participation in  
8 this litigation with regards -- that pertains  
9 to Carole Rendon or Baker Hostetler. So just  
10 noted objection that we have.

11 MR. CHEFFO: Okay.

12 MS. HARTMAN: I -- just to note a --  
13 and just to note a response, the Endo  
14 defendants would be prejudiced without counsel  
15 here. Thanks.

16 BY MR. CHEFFO:

17 Q. Okay. Mr. Shannon, I want to ask  
18 you some questions. We started with Exhibit 1.  
19 But before we do that, if I could just -- just  
20 have a few kind of clarifying questions or  
21 follow-up, if I could.

22 So before we move to this, are you  
23 aware of any case in the county where an  
24 individual who used a prescription as directed  
25 by a doctor died of a -- an overdose related to

1           that?

2           A.       Who used a prescribed opiate --

3           Q.       As directed.

4           A.       As directed.

5                   That's -- you know, that'd probably  
6       be better to ask Dr. Gilson. I...

7           Q.       But you're not ware of any --  
8       anything like that, are you?

9           A.       I'm not aware, no.

10          Q.       Dr. Gilson would be the person to --  
11       to be able to answer that question?

12                   MR. GALLUCCI: Object to form.

13                   THE WITNESS: Well, he's the medical  
14       examiner and a forensic pathologist. That's  
15       more or less a -- a medical question, I think.

16                   BY MR. CHEFFO:

17          Q.       And -- and are -- do you think, if  
18       you queried your various databases and sources,  
19       you could -- you could determine that  
20       information?

21                   MR. GALLUCCI: Object to form.

22                   THE WITNESS: Not the databases I  
23       have access to. It doesn't say -- you know, it  
24       just gives the cause of death.

25                   BY MR. CHEFFO:

1           Q.       And we talked about certain  
2       limitations in the data -- in the 2012 and '13  
3       data.

4                    Do you recall that?

5           A.       Specifically what?

6           Q.       Well, so for OARRS, it didn't list  
7       why a prescription was made, right?

8           A.       Well, the OARRS database doesn't  
9       have that information in it, no. I'm not sure  
10       that's a limitation on the system. Because  
11       that's not the intent of the -- the system.

12          Q.       Okay. Well, with respect to any  
13       data that's used to analyze -- well, strike  
14       that.

15                   With respect to data that is used  
16       by -- by your office, by your department, in  
17       order to take a look at issues involving the  
18       opioid crisis, is -- is it the standard  
19       practice to determine why a prescription  
20       medicine was written if there is a record of  
21       prescription medicine?

22          A.       Only if it pertains to the cause of  
23       death.

24          Q.       And -- and how do they do that?

25          A.       That's a doctor question.



1           Q.     And what about identifying a full  
2     drug history; is that part of the standard  
3     protocol in a overdose death?

4           A.     To the best that it can be  
5     determined, yes.

6           Q.     Well, do you go and find out -- does  
7     the department go and find out if -- let's say  
8     someone's a -- an employee -- a government  
9     employee.

10           Do you access or ask to access their  
11     prescription records?

12           A.     I'm not sure I understand what  
13     you're asking me.

14           Q.     Well, their drug history, including  
15     non -- nonopioid drugs.

16           In other words, is part of the  
17     protocol to find out whether -- you know, and  
18     I -- I -- I said "government employee" because  
19     you might have access to that, right?

20           Whatever your health care provider  
21     is, is there an effort to go and say to  
22     whatever -- whether it's Blue Cross or Aetna or  
23     United Health -- send an authorization or get  
24     the records to find out what medicines that  
25     person may have been tacking?

1           A.       So OARRS does that for us. So I'm  
2 not sure what the need would be.

3           Q.       Does OARRS --

4           A.       So --

5           Q.       But OARRS only does controlled  
6 substances, right?

7           A.       Correct.

8           Q.       But what happens if someone was  
9 taking -- there are other substances that can  
10 be involved in overdose deaths, right, other  
11 than controlled substances?

12          A.       Correct.

13          Q.       And there could also be other  
14 beneficial medicines that could inform  
15 someone's view about the health of a patient,  
16 right, or decedent, right?

17               MR. GALLUCCI: Object to form.

18               THE WITNESS: Again, that would be  
19 the doctor's determination, not anything that  
20 I'm involved with.

21               BY MR. CHEFFO:

22          Q.       Right.

23               I'm just trying to find out, as part  
24 of the protocol and being at the office, do you  
25 -- are you aware of whether the department

1 regularly accesses prescription information  
2 about a decedent?

3 A. Yes. Through OARRS.

4 Q. Only through OARRS.

5 A. Unless it's in their medical  
6 records.

7 Q. So if someone was taking blood  
8 pressure medicine, how would they -- that would  
9 only be something that the department would  
10 evaluate if it was in medical records?

11 A. So if somebody dies, say in their  
12 home, and our investigators are on the scene,  
13 again, I think I mentioned earlier any  
14 prescription pills that might be on the scene  
15 get collected, we document. So that is a way  
16 to determine whether or not someone has other  
17 prescriptions.

18 Sometimes family history will be  
19 given at the scene. He had high blood  
20 pressure. He was taking this drug. It'll be  
21 noted in the investigator's report possibly.

22 Again, anything that is in a  
23 person's system will show up on the toxicology  
24 report. It's really up to the doctor, the  
25 forensic pathologist, to determine whether it

1 has any relationship to the cause of death.

2 Q. And I -- I -- and -- and I  
3 appreciate that. I'm just asking just a much  
4 more specific question.

5 Is it part of the protocol to get  
6 prescription -- a history of prescription  
7 records outside of the things you've talked  
8 about: interviews, scene investigation or  
9 checking OARRS?

10 A. There may be other methods. I'm not  
11 aware of a protocol of our office to call a  
12 person's insurance company after they've died,  
13 no.

14 Q. Okay. And I -- and tell me if I got  
15 this right, but I thought you said that you  
16 believed -- that you couldn't point to any  
17 individual and didn't believe -- well, strike  
18 that.

19 I think you testified that there  
20 were a certain number of heroin deaths --  
21 overdose deaths that you believe were  
22 potentially linked to a prescription opioid; is  
23 that right?

24 A. Correct.

25 Q. And you don't know the percentage,

1 do you?

2 A. I do not.

3 Q. It's not a hundred percent, right?

4 MR. GALLUCCI: Object to form.

5 THE WITNESS: I don't know the  
6 percentage.

7 BY MR. CHEFFO:

8 Q. Right.

9 But you -- it's not your testimony  
10 that every heroin death is linked to a  
11 prescription overdose, is it?

12 For the reasons we've just been  
13 talking about.

14 A. So what we have been informed of and  
15 what we have learned over these years is that  
16 the cartels in Mexico ramped up their heroin  
17 production knowing that there was a market  
18 created by a flood of prescribed opiates into  
19 communities that people would turn to other  
20 means if they were no longer be able to access  
21 their prescription opioids.

22 Q. Okay.

23 A. That --

24 Q. Sorry.

25 A. The sophistication of these cartels

1       that they are -- they track these things.

2       So -- we've heard that from case studies from  
3       our law enforcement partners. They're -- they  
4       knew that, when pill mills were going to get  
5       cracked down on in Ohio, that there would be a  
6       market for their product.

7             Q.       Right.

8                     And we talked a little -- we can go  
9       back to it.

10                    But I thought we talked about that  
11       that was a theory, right?

12                    But in order to determine whether  
13       someone actually was the person who was  
14       prescribed from a pill mill, lost their  
15       insurance, lost their -- their access to an  
16       opioid, and then later became a heroin addict  
17       and overdosed, right, that's information that  
18       you could look at, but you don't have the  
19       specifics, right?

20             A.       Not specifics.

21             Q.       Right.

22                    And -- and you would agree with me  
23       that -- that not every person -- so, for  
24       example, if a 21-year-old unfortunately went  
25       out today on the street and had never had a

1 prescription for opioids, never used opioids  
2 before, experimented with illicit fentanyl and  
3 unfortunately overdosed, that wouldn't be  
4 related to the prescription opioid, right?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: Now, other than the  
7 fact that, like I said, cartels pumped up their  
8 production based on what they knew about the  
9 market for prescription opiates. And so maybe  
10 we wouldn't have so much illicit fentanyl on  
11 the streets had it not been for that fact.  
12 So...

13 BY MR. CHEFFO:

14 Q. Is that a speculation, or -- or do  
15 you have details about that?

16 A. What kind of details? I think it's  
17 fairly common amongst people who are dealing  
18 with this day in and day out in treatment, law  
19 enforcement. These are the people that we  
20 talked to at the task force.

21 Q. So would you say that the cartels  
22 are just businessmen who are taking advantage  
23 of a opportunity, or do they have some  
24 culpability for shipping in --

25 A. No. They're criminals.

1 Q. Right.

2 MR. GALLUCCI: Let's -- let's let  
3 him finish his --

4 THE WITNESS: Oh, sorry.

5 MR. GALLUCCI: -- question before  
6 you answer.

7 BY MR. CHEFFO:

8 Q. I mean they're -- right.  
9 I mean that -- they're criminals,  
10 right?

11 A. They're -- they are criminals. And  
12 they -- you know, I'm not suggesting that  
13 they're stand-up professionals. But i -- what  
14 I'm saying is -- is that we're told that the  
15 operations that they run are very  
16 sophisticated, and we shouldn't underestimate  
17 what they do and don't know about the markets  
18 that they're --

19 Q. Right.

20 A. -- that they're operating in.

21 Q. And -- and -- and they are  
22 sophisticated and try to take advantage of  
23 vulnerable people, both in Cuyahoga County,  
24 frankly in all of our communities, right?

25 A. That's the business model, yeah. I



1 believe so.

2 Q. And -- and they have certainly some  
3 responsibility for the opioid crisis here in  
4 Cuyahoga and elsewhere in the country, right?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: So they certainly  
7 have -- don't have any -- no responsibility.  
8 But again, it's a combination that, you know,  
9 the market was already created for them.

10 BY MR. CHEFFO:

11 Q. Do the -- do the -- do the person on  
12 the street who actually sells the cocaine laced  
13 with fentanyl or the fentanyl to the  
14 individual, does that person have some  
15 responsibility if that -- if -- if their  
16 customer takes the illicit drug and overdoses  
17 and dies?

18 MR. GALLUCCI: Object to form.

19 THE WITNESS: I believe that's what  
20 the Prosecutor's Office and the U.S. Attorney's  
21 Office, when they prosecute those people that  
22 they do catch.

23 BY MR. CHEFFO:

24 Q. Right.

25 And they prosecute them because they

1 know that, if you -- if you stopped or  
2 curtailed the drug cartel, you would reduce the  
3 amount of overdose deaths, right?

4 I mean that's what they're trying to  
5 do, isn't it?

6 MR. GALLUCCI: Object to form.

7 THE WITNESS: I think they're trying  
8 to enforce the law.

9 BY MR. CHEFFO:

10 Q. Right.

11 But isn't it common sense that the  
12 reason why they're trying to enforce the law --  
13 I mean this is not like jaywalking, right?

14 They're trying to enforce law and  
15 stop the cartels because they know, if they do  
16 that, they can prevent many or all of the  
17 overdose deaths from illegal substances like  
18 fentanyl and illicit fentanyl.

19 MR. GALLUCCI: Object to form.

20 THE WITNESS: Not all.

21 BY MR. CHEFFO:

22 Q. But isn't it common sense that  
23 that's what they're trying to do, stop the  
24 drugs from coming in as part of this massive  
25 influx so that they could reduce the overdose

1 deaths in the county?

2 A. So that is part of the coordinated  
3 strategy is to stop drugs from coming into the  
4 country, yes.

5 Q. Right.

6 Because those people who are sending  
7 the drugs in the country have -- are aware of  
8 where the drugs are coming from, and that's  
9 where the people can access them, right?

10 A. Well, that's -- they know that's  
11 where the illicit drugs are coming from, yes.

12 Q. Right.

13 And those people, you would agree  
14 that they have a significant responsibility for  
15 the illegal drug trade and the overdoses based  
16 on illegal drugs.

17 MR. GALLUCCI: Object to form.

18 THE WITNESS: So you're asking  
19 multiple questions within a question.

20 MR. CHEFFO: Okay. I could break it  
21 down.

22 THE WITNESS: Could you?

23 BY MR. CHEFFO:

24 Q. Sure.

25 Is there really any dispute amongst

1 people that the drug cartels have  
2 responsibility for people who ingest the drugs  
3 that they send into the country and ultimately  
4 die?

5 A. Any? That's a broad category. I  
6 can't speak for all people. I can speak for  
7 what I know.

8 Q. Okay. What do you know?

9 A. So the -- yes, there are -- people  
10 who sell illicit drugs, who manufacture illicit  
11 drugs and ship illicit drugs into this country  
12 bear some responsibility, not all.

13 The market was not created by them.  
14 They were created by massive distributions in  
15 dispensing of prescription opioids.

16 Q. Yeah. And I -- I'm going to get to  
17 that. But I want to just -- let's just take it  
18 one chain at a time.

19 So the cartels, they clearly have  
20 some responsibility, right, by creating  
21 these -- these illegal drugs that are shipped  
22 into the country that are used unlawfully.

23 MR. GALLUCCI: Object --

24 BY MR. CHEFFO:

25 Q. Agree?

1 MR. GALLUCCI: Object to form.

2 THE WITNESS: Yes.

3 BY MR. CHEFFO:

4 Q. Do people who abuse the drugs have  
5 any responsibility?

6 MR. GALLUCCI: Object to form.

7 THE WITNESS: It's an illness, so...

8 BY MR. CHEFFO:

9 Q. So is the answer yes or no?

10 A. The illness is not of their making  
11 and is not really under their control. So I  
12 would say that they bear no responsibility.  
13 They really need medical attention.

14 Q. Are they prosecuted if they are  
15 caught with it?

16 A. I don't believe so anymore, that  
17 that is kind of an old practice.

18 Q. Fentanyl?

19 A. People who are using fentanyl, yes,  
20 I -- the basic protocols that are in place now  
21 is to get those people treatment and help, not  
22 to prosecute.

23 Q. Are there -- so it is your testimony  
24 that everybody who uses illicit fentanyl is not  
25 responsible for their actions?

1 MR. GALLUCCI: Object to form.

2 THE WITNESS: I'm saying that people  
3 who are addicted to opioids are not  
4 responsible, that they need medical attention  
5 like any other medical condition. You don't  
6 arrest people because they're having a heart  
7 attack because they had a cheese burger. It's  
8 not a condition that they control. They just  
9 need treatment.

10 BY MR. CHEFFO:

11 Q. And that -- that -- that's every  
12 single person who abuses fentanyl or --

13 A. So I'm not in law enforcement. I am  
14 not a doctor. What has been explained to me  
15 and what is my understanding, being in these  
16 task forces with those people, is that it's a  
17 medical condition that needs treatment.

18 Q. Is the same true for people who  
19 abuse cocaine?

20 A. I'm not an addiction specialist. I  
21 couldn't answer.

22 Q. Well, is there any difference  
23 between cocaine and fentanyl or heroin in your  
24 mind --

25 A. Well --

1           Q.       -- in terms of the population of  
2 people who abuse them?

3           MR. GALLUCCI: Object to form.

4           THE WITNESS: From the data that we  
5 see, there are some differences. But again,  
6 I'm not an addiction specialist. I'm not in  
7 law enforcement. I really couldn't speak to  
8 that.

9           BY MR. CHEFFO:

10          Q.       And the -- the street dealer, if he  
11 or she sells illegal drugs, they have some  
12 responsibility, I take it?

13          MR. GALLUCCI: Object to form.

14          THE WITNESS: When you say  
15 "responsibility," I -- it's -- if you break law  
16 and they get caught, they get prosecuted.

17          BY MR. CHEFFO:

18          Q.       Right.

19                 But responsibility, what we're  
20 talking about, I think, today is your office,  
21 overdose deaths, right?

22                 Do they have some responsibility --  
23 if they sell an illegal drug to an individual,  
24 and he or she unfortunately overdoses, does the  
25 street dealer have responsibility and

1           culpability for that death?

2                   MR. GALLUCCI: Object to form.

3                   THE WITNESS: Our office doesn't  
4           make that determination. We are basically in  
5           the business of determining a quasi manner of  
6           death.

7                   BY MR. CHEFFO:

8                   Q.       I'm asking you as a -- as a -- an  
9           upstanding citizen in -- in this community.  
10           What do you think?

11                   MR. GALLUCCI: Object to form.

12                   THE WITNESS: Like everything else,  
13           they are breaking the law. They should be  
14           prosecuted to the fullest extent. They're  
15           still operating in the same environment that  
16           was created due to the flood of prescription  
17           opioids.

18                   BY MR. CHEFFO:

19                   Q.       Are they just businessmen who are  
20           just taking advantage of an opportunity?

21                   A.       No. I said they're criminals that  
22           should be prosecuted to the fullest extent of  
23           the law.

24                   Q.       You seem --

25                   A.       But they're operating in an



1 environment that was created by the flood of  
2 prescription opioids.

3 Q. You seem to want to -- to really --  
4 you're -- you're kind of fighting me on the --  
5 the idea that somebody who sells street drugs  
6 to someone who then overdoses, that you don't  
7 want to say that they have liability.

8 Is that -- am I reading that right?

9 MR. GALLUCCI: Object to form.

10 He answered the questions?

11 THE WITNESS: So I'm not a lawyer.  
12 So liability doesn't mean all that much to me.  
13 Responsibility --

14 BY MR. CHEFFO:

15 Q. Okay. Let's use --

16 A. -- they use the --

17 Q. -- "responsibility."

18 A. Again, if they break the law, they  
19 need to be prosecuted to the fullest extent.

20 Q. Do they have --

21 A. They operate in the environment that  
22 was created.

23 Q. Do they have response -- does  
24 someone who sells illegal drugs to someone who  
25 then uses them and overdoses and dies have

1 responsibility for their death?

2 A. I believe I --

3 MR. GALLUCCI: Object to form.

4 THE WITNESS: -- just answered that  
5 question.

6 BY MR. CHEFFO:

7 Q. I don't think you did.

8 Is it yes or no?

9 A. So --

10 MR. GALLUCCI: Object to form.

11 It doesn't have to be a yes-or-no  
12 answer either. You can give whatever answer  
13 you believe is accurate.

14 THE WITNESS: I gave the most  
15 complete --

16 BY MR. CHEFFO:

17 Q. You said --

18 A. -- and accurate answer that I have  
19 already.

20 Q. I think you said they should be  
21 prosecuted.

22 I'm just asking you do they have  
23 some responsibility at all for the death?

24 MR. GALLUCCI: Object to form.

25 THE WITNESS: I -- again, I believe

1 I've answered your question several times now.

2 BY MR. CHEFFO:

3 Q. I don't think you've, sir.

4 MR. GALLUCCI: Object to form.

5 THE WITNESS: It's not our office's  
6 determination whether -- who is and isn't  
7 responsible.

8 BY MR. CHEFFO:

9 Q. Okay. And I'm not asking you on  
10 behalf of the office. I'm asking you as a fact  
11 witness here today and someone lives in the  
12 community. You've testified a lot about all  
13 the things in the task forces.

14 So my question again is you  
15 individually, do you believe somebody who sells  
16 drugs illegally to an individual who uses the  
17 drugs, overdoses and dies, does that drug  
18 dealer have responsibility in some way for the  
19 individual's death?

20 MR. GALLUCCI: Object to form.

21 THE WITNESS: Again, me personally,  
22 I believe that they need to be prosecuted.  
23 Prosecution is a legal process. It determines  
24 responsibility. That's --

25 MR. CHEFFO: Okay.

1 THE WITNESS: -- outside my purview.

2 BY MR. CHEFFO:

3 Q. What about a doctor who prescribes  
4 controlled substances knowing that they're not  
5 for legitimate purposes; do they have -- and  
6 the person ultimately either overdoses or has  
7 subsequent events in life that lead them to a  
8 very negative place; does that doctor have  
9 responsibility?

10 MR. GALLUCCI: Object to form.

11 THE WITNESS: Not being a doctor, I  
12 don't know how to determine whether they  
13 knowingly or unknowingly are doing it for  
14 legitimate reasons or not -- illegitimate  
15 reasons.

16 BY MR. CHEFFO:

17 Q. Okay. And fair enough. And I'm not  
18 asking you to be a doctor.

19 But let's -- let's assume there's a  
20 person who was prosecuted and either pled  
21 guilty or convicted -- or was convicted, right,  
22 of unlawfully prescribing, like a pill mill  
23 doctor, right?

24 Does that person have responsibility  
25 for any harm that was caused by their

1 prescription of those -- those medicines in an  
2 unlawful way?

3 A. Well, if they've been convicted,  
4 then a court system -- the judicial system has  
5 determined responsibility --

6 Q. And --

7 A. -- of that individual.

8 Q. And you -- you would agree with that  
9 then?

10 A. I --

11 MR. GALLUCCI: Object to form.

12 THE WITNESS: I'm not in a position  
13 to agree or disagree with the court. It's --  
14 I'm not in the proceedings. I assume that  
15 things are done properly.

16 But as an individual, I -- how would  
17 I be able to say whether or not an individual  
18 judge or an individual case was done right or  
19 wrong?

20 BY MR. CHEFFO:

21 Q. When you were look -- when you look  
22 back at the data to find out if somebody was --  
23 if somebody's listed in the OARRS system for a  
24 controlled substance, right, when you look at  
25 that, wouldn't it be interesting and helpful

1 information if you knew or evaluated whether  
2 the -- the OARRS prescription was written by  
3 somebody who was ultimately convicted for  
4 improperly prescribing medicines?

5 A. Well, we don't -- we don't usually  
6 worry about what is and isn't interesting. It  
7 doesn't have any determination as to the  
8 ultimate cause and manner of death. So for the  
9 purposes of our mission and our statutory  
10 responsibilities, it doesn't -- doesn't play a  
11 role.

12 Q. Well, don't -- I thought you told me  
13 that you guys in your office -- not -- excuse  
14 me. Not you guys -- your office is doing a lot  
15 of work beyond just determining cause of death  
16 in individual cases, right?

17 You're trying to do studies and  
18 reports and publish things and do informational  
19 dives that you believe could be helpful from a  
20 public health perspective.

21 A. Correct.

22 Q. That's part of the mission, too,  
23 right?

24 A. Yes, it is.

25 Q. So as part of that aspect of your

1 mission, and you're trying to determine, for  
2 example, if someone who overdosed received a  
3 prescription, wouldn't you want to know whether  
4 the prescription was written by somebody who  
5 was later prosecuted and convicted in the  
6 county for -- for improperly prescribing that  
7 drug?

8 A. So we get calls from various  
9 enforcement agencies asking for additional  
10 information. We provide it when it's asked.

11 It doesn't really -- I don't know  
12 how it would -- that information would better  
13 inform the doctors in their work or the  
14 scientists in their work. I'm sure it would be  
15 useful to the overall task force and certain  
16 parts of it more than others.

17 Q. Well, part of what you've told us  
18 earlier is that you've -- you're tried to -- to  
19 look at certain data to draw some conclusions  
20 about populations of people who overdosed who  
21 previously used some type of either legal or  
22 illegal opioid, right?

23 A. Correct.

24 Q. And there's been a lot of work done  
25 on that, right?

1           A.       Yes.

2           Q.       And you've -- you've -- we talked  
3       about some of the data sources and some of the  
4       limitations of the information available to  
5       you, right?

6           A.       Yes.

7           Q.       And in connection with that work,  
8       you have looked at or tried to look at various  
9       factors that could potentially impact both an  
10      individual and a population, right?

11                   MR. GALLUCCI: Object to form.

12                   THE WITNESS: Yes.

13                   BY MR. CHEFFO:

14           Q.       It could be age; it could be sex; it  
15      could be whether they were previously  
16      incarcerated; it could be whether they used  
17      Naloxone, right?

18           A.       Yes.

19                   MR. GALLUCCI: Object --

20                   BY MR. CHEFFO:

21           Q.       And there's probably other factors,  
22      right?

23                   MR. GALLUCCI: Object to form.

24                   THE WITNESS: Yes.

25                   BY MR. CHEFFO:



1           Q.       And that's because this is a  
2       multifactorial problem, and it's -- there's no  
3       easy solution to addiction or overdose deaths,  
4       right?

5                   MR. GALLUCCI:   Object to form.

6                   THE WITNESS:   I'm not sure the --  
7       the solution is all that intricate.   Getting  
8       people off drugs and in treatment, it's fairly  
9       straightforward.   It's more a matter of  
10      resources.

11                  It's a -- it's a particularly  
12      difficult addiction to break, yes.

13                  BY MR. CHEFFO:

14           Q.       Let's look at Exhibit 1, please, Mr.  
15      Shannon.

16                  And to reorient you, this is a  
17      document dated 2016 put out by the Cuyahoga  
18      County Board of Health, right?

19           A.       Yes.

20           Q.       Have you -- did you participate in  
21      the preparation of this document?   Is that  
22      within your purview?

23           A.       I did not.

24           Q.       And do you see the -- on the --  
25      there's no pages again.   I apologize.   But the

1       third page, if you count the cover as one,  
2       right, then two, three. It says "How did this  
3       happen?"

4               MR. GALLUCCI: Mr. Cheffo, just to  
5       be clear, is that Bates No. 18267?

6               MR. CHEFFO: Yes. Thanks. I should  
7       have used that.

8               MR. GALLUCCI: Yes.

9               BY MR. CHEFFO:

10       Q. Do you see that, sir?

11       A. Yes.

12       Q. And -- and again, it says there are  
13       several contributing factors that led to this  
14       epidemic.

15               Do you see that?

16       A. Yes.

17       Q. I think we agreed that that's in  
18       connection with what's being called the opioid  
19       epidemic?

20               MR. GALLUCCI: Object to form.

21               THE WITNESS: Yes.

22               BY MR. CHEFFO:

23       Q. And one of them is "Changes made to  
24       chronic pain management guidelines during the  
25       late 1990s," right?

1           A.       That's how it reads.

2           Q.       "Marketing medications directly to  
3 the consumer."

4                   Do you see that?

5           A.       I do.

6           Q.       "Overprescribing of high potency  
7 pain medication."

8                   Do you see that?

9           A.       I see that.

10          Q.       And then it says: "HCA HPS/Press  
11 Ganey scores (patient satisfaction surveys)  
12 that directed hospital reimbursement."

13                   Do you see that?

14          A.       I do.

15          Q.       And then it says: "Abuse  
16 deterrents, formulations of medications that  
17 may have inadvertently shifted abuse towards  
18 heroin."

19                   Do you see that?

20          A.       I do.

21          Q.       Then it says: "Mass incarceration  
22 for" violent -- I'm sorry -- "for nonviolent  
23 drug-related crimes."

24                   Do you see that?

25          A.       I do.

1 Q. "Lack of treatment availability"?

2 A. I see that.

3 Q. And then it says: "Stigma, viewing  
4 drug addiction as a moral failing."

5 Do you see that?

6 A. I do.

7 Q. Do you agree with all those factors?

8 MR. GALLUCCI: Object to form.

9 THE WITNESS: Personally or as a...

10 BY MR. CHEFFO:

11 Q. You can answer either way, sir, or  
12 both.

13 MR. GALLUCCI: Just to clarify,  
14 you're here as a fact witness today, not as a  
15 30(b).

16 THE WITNESS: I don't believe this  
17 is an exclusive list. But I believe -- I agree  
18 with what's written here, yes.

19 BY MR. CHEFFO:

20 Q. What other factors would you add to  
21 the list?

22 Would you add the -- the things  
23 we've talked about, the drug -- influx of drug  
24 cartels and drug sales from foreign countries?

25 MR. GALLUCCI: Object to form.

1 THE WITNESS: So one of the things  
2 that had been talked about throughout the  
3 preparation for the first Summit during the  
4 task force -- the U.S. Attorney's task force  
5 was the lack of -- it says "Lack of treatment  
6 availability."

7 But there were specific regulations  
8 that the IMD -- IMBD exclusion that limited  
9 beds to 16. And that was something that we had  
10 talked about regularly.

11 We had talked about -- there were  
12 discussion about guidelines to limit dosage and  
13 the number of days supply of prescribed opiates  
14 that -- that should -- might be available in --  
15 in some cases.

16 BY MR. CHEFFO:

17 Q. So just on those, Mr. Shannon, let's  
18 me see if I understand that right -- so the --  
19 would -- would you say that a factor were kind  
20 of a regulatory and healthcare environment that  
21 contributed to the lack of availability of  
22 necessary beds?

23 A. It was certainly part of the  
24 discussion at the time, yes.

25 Q. And it would -- it -- I take it,

1 from where you say "the guidelines," it would  
2 be a -- a lack of guidelines that might have  
3 been more stringent in prescribing or  
4 proscribing the way and the manner in which the  
5 medicines were prescribed?

6 A. That was the discussion, especially  
7 among the -- the medical experts in the room,  
8 yes.

9 Q. And I take it that made sense to  
10 you, and you adopt -- you believe that?

11 A. That was the basic understanding of  
12 the entire group. And as we move forward,  
13 those were things that we did advocate for as a  
14 group, yes.

15 Q. Was there anything about  
16 reimbursement for other types of treatments or  
17 modalities by insurance companies that would  
18 reduce the way that prescriptions for opioids  
19 might have been reimbursed?

20 MR. GALLUCCI: Object to form.

21 THE WITNESS: Yeah, I'm not sure.

22 I -- I don't know if you want to --

23 MR. CHEFFO: Sure.

24 THE WITNESS: -- rephrase it.

25 BY MR. CHEFFO:

1           Q.     In other words, have -- have you --  
2     have you ever heard someone saying, "Well, if  
3     -- if we reimbursed for psychotherapy or  
4     acupuncture or some alternative therapies" --

5           A.     Yeah.

6           Q.     -- "as opposed to not reimbursing or  
7     making them more challenging to access or  
8     doctors to use those, that contributed to  
9     overprescriptions and was part of the  
10    complicated problem that we now all face"?

11          A.     Well, I don't know if it contributed  
12    to overprescriptions. There was discussion  
13    about alternate pain management methods.  
14    Again, I -- I was in the room when those were  
15    taking place, but that's not really my area.  
16    That was really the medical professionals in  
17    the reasonable that -- that had those  
18    discussions.

19          Q.     In getting back to, you know, just  
20    -- and I'm asking your own view. When we talk  
21    about the various factors, you've adopted these  
22    and the others that -- that you've just  
23    testified about.

24                 But would you -- look -- looking  
25    back about how did this happen, would you also

1 add doctors who were unethical, who prescribed  
2 medicines for their personal economic gain as  
3 opposed to their patients' interests, if that  
4 happened?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: I don't recall that as  
7 a specific talking point. I believe most of it  
8 was focused on just the overall guidelines and  
9 lowering the dosage -- the daily dosage and the  
10 amount of days of prescriptions that were  
11 available.

12 BY MR. CHEFFO:

13 Q. Okay. And let me just be clear. I  
14 know I put this document in front of you. So I  
15 didn't mean to confuse you on this. But I'm  
16 just now -- I'm going off this document and  
17 asking for your -- your view.

18 In addition to the factors that  
19 we've just talked about, which were talked  
20 about and adopted by the Board of Health, do  
21 you also believe that, again, the -- if the  
22 question is factors that led to the opioid  
23 problem or crisis, would you also include  
24 doctors who improperly prescribed medicines for  
25 their own personal gain?



1 MR. GALLUCCI: Object to form.

2 THE WITNESS: I -- I wouldn't really  
3 have a way of determining how much of that  
4 contributed.

5 BY MR. CHEFFO:

6 Q. Right.

7 But did it contribute at all?

8 MR. GALLUCCI: Have you finished  
9 answering the question?

10 MR. CHEFFO: Sorry. I thought you  
11 were done. I didn't --

12 MR. GALLUCCI: Yeah. Just --

13 MR. CHEFFO: -- mean to interrupt  
14 you.

15 No. That's okay.

16 THE WITNESS: So I -- yeah. I'm not  
17 sure that I could -- I could -- I wouldn't put  
18 it in a bullet point. I don't think that it  
19 had as big or as significant -- at least from  
20 the time that I have been involved in the -- in  
21 the U.S. Attorney's task force.

22 BY MR. CHEFFO:

23 Q. And again, I'm -- I'm not asking  
24 about the attorney's task force or any task  
25 force. I'm asking about you. And -- and I'm

1 not asking you at this point to quantify  
2 exactly what percentage.

3 But would you agree that it was a  
4 factor in the aggregate?

5 And -- and we'll go through a few of  
6 them.

7 But was it a factor in the aggregate  
8 for doctors who unethically or improperly or  
9 criminally prescribed opioids for their own  
10 personal gain?

11 MR. GALLUCCI: Object to form.

12 THE WITNESS: I wouldn't say it was  
13 zero. But again, the contributing factors of  
14 the flood of -- and the tactics that were used  
15 to market and -- and distribute, it set up more  
16 that -- that that case would be more likely.

17 BY MR. CHEFFO:

18 Q. Okay. So it's not zero, but I -- am  
19 I correct, if I asked you to assign a  
20 percentage, you couldn't tell me; you just know  
21 that it was a factor; you can't say that --  
22 what -- what percentage, right?

23 MR. GALLUCCI: Object to form.

24 THE WITNESS: I can't give you a  
25 percentage.

1 MR. CHEFFO: Okay.

2 THE WITNESS: Again, these people  
3 are operating in an environment that was  
4 created because of the flood of prescription  
5 opioid.

6 BY MR. CHEFFO:

7 Q. We're -- we're talking about doctors  
8 now who prescribed opioids to people for  
9 unethical and immoral purposes.

10 A. Uh-huh.

11 Q. Right?

12 A. That's your question, yes.

13 Q. Right.

14 And you say it was creating an  
15 environment.

16 Do you know whether -- what -- what  
17 happens if -- if the -- if that was the first  
18 time someone ever took an opioid was as a  
19 result of a pill mill doctor; does that have  
20 anything to do with the -- the environment?

21 A. The first time ever?

22 Q. Yeah.

23 A. Like civil war? I mean --

24 Q. No.

25 A. -- first time ever --

1 Q. First time ever that person?

2 A. -- I mean hopefully then -- I'm --

3 Q. No. Sorry.

4 First time ever that person.

5 A. That specific person. Okay.

6 Q. Right. I'm not talking back

7 history --

8 A. Okay.

9 Q. -- or thousands of years.

10 But let -- let me rephrase it so

11 we're on the same page.

12 To the extent a person went to an  
13 unscrupulous doctor who prescribed an opioid  
14 for improper purposes or nonmedical purposes to  
15 someone, and that was the first introduction  
16 for that person of an opioid in their life, and  
17 that person ultimately went on to have an  
18 addiction disorder or an overdose, the doctor  
19 who prescribed that would have -- that would be  
20 a factor in their ultimate abuse and overdose,  
21 right?

22 A. Again, it wouldn't -- it wouldn't be  
23 a zero contributing factor, no. It would be --  
24 but again, it's not the overriding.

25 Q. Really? The doctor who prescribed

1       it, that -- that's nothing the overriding cause  
2       of the person's death?

3               MR. GALLUCCI: Object to form.

4               THE WITNESS: So again, by providing  
5       far more prescription pills, doses in a  
6       community than was necessary by direct  
7       marketing, by all of these factors that opioid  
8       manufacturers and distributors undertook,  
9       including pressuring doctors, I mean...

10              BY MR. CHEFFO:

11              Q.     Do you know that?

12              A.     It's not -- do I know it?

13              Q.     Yeah.

14              I mean do -- are you aware of any  
15       details of any doctor who was prescribed that  
16       they ever saw any of --

17              A.     I'm sure --

18              Q.     -- that information?

19              A.     -- you'll have expert witnesses that  
20       will provide that information. I -- I'm not  
21       here for that purpose.

22              Q.     So I just want to make sure that I'm  
23       really understanding your testimony.

24              So your -- your testimony is that,  
25       if a -- a pill mill doctor who gets prosecuted

1       for prescribing medicines to someone, and that  
2       person goes out and -- and dies unfortunately  
3       of an overdose, that you're not willing to --  
4       to basically say that they have substantial  
5       responsibility for that death, and you're --  
6       it's somebody else's problem?

7           A.       It's not my --

8                   MR. GALLUCCI:   Object to form.

9                   THE WITNESS:   -- place to determine  
10       substantial --

11                  MR. GALLUCCI:   Object to form.

12                  THE WITNESS:   Sorry.

13                  BY MR. CHEFFO:

14       Q.       Well, do they?

15       A.       -- what is and isn't substantial.   I  
16       said --

17       Q.       Do you believe it?

18       A.       I said it's not zero.

19       Q.       Is it more than 50 percent?

20                  MR. GALLUCCI:   Object to form.

21                  THE WITNESS:   I've already answered.  
22       I'm not giving you a percentage.   I don't have  
23       a percentage for you.   It's not zero.   I don't  
24       think it's significant enough to put on the  
25       bullet point list.

1 BY MR. CHEFFO:

2 Q. For that individual it's  
3 significant.

4 A. I understand that.

5 MR. GALLUCCI: Object to form.

6 BY MR. CHEFFO:

7 Q. Let's talk about that individual.  
8 In terms of factors that led that  
9 person to overdose and die, how significant is  
10 it?

11 MR. GALLUCCI: Object to form.

12 THE WITNESS: I would have to see  
13 the exact case. And that's not my  
14 determination. That's the medical examiner's  
15 determination.

16 BY MR. CHEFFO:

17 Q. I understand. But I'm just giving  
18 you some facts, right, to -- to -- in a  
19 hypothetical.

20 Someone who never used opioids, went  
21 to an unscrupulous doctor, was prescribed  
22 opioids improperly, and they didn't need them,  
23 and the doctor did it just to make money on it,  
24 and the person ultimately developed an abuse  
25 disorder and overdosed and died.

1                   In that individual, how significant  
2                   is the doctor's role in that course of conduct?

3                   A.       Again, that would be a --

4                   MR. GALLUCCI:   Object to form.

5                   THE WITNESS:   -- determination by a  
6                   medical professional, not...

7                   BY MR. CHEFFO:

8                   Q.       Really?

9                   If that happened to a friend of  
10                  yours, what would -- what would your view be?

11                  A.       It has happened.   It has happened  
12                  over and over again a thousand times over in  
13                  this community over the last few years.

14                  Q.       Unscrupulous doctors prescribing  
15                  medicines?

16                  A.       No.   People --

17                  MR. GALLUCCI:   Object to form.

18                  THE WITNESS:   -- dying of overdoses.

19                  BY MR. CHEFFO:

20                  Q.       I get --

21                  A.       Opioids.

22                  Q.       I'm talking about my specific  
23                  hypothetical right now, sir.

24                  A.       Right.

25                  Q.       And --



1           A.     I don't think I'm here to deal with  
2     hypotheticals. I'm here try to give you the  
3     facts as I know them. So...

4           Q.     I understand.

5                     You're -- you're not willing to tell  
6     me that they are substantially responsible?

7           MR. GALLUCCI: Object to form.

8           THE WITNESS: I don't have a  
9     specific case to determine that. And that's  
10    not my job as head of operations at the Medical  
11    Examiner's Office. I can't give you an answer.

12          BY MR. CHEFFO:

13          Q.     Well, you're -- you're a person who  
14     sits on these task force, right, to try and  
15     help develop public policy; isn't that right?

16          A.     The U.S. Attorney's task force I sit  
17     on, yes.

18          Q.     And you attended the Board of  
19     Health?

20          A.     I do not.

21          MR. GALLUCCI: Object to form.

22          BY MR. CHEFFO:

23          Q.     You never have?

24          A.     I have not.

25          Q.     Okay. Do you believe most people in

1       this community would say that, if a doctor  
2       prescribed a medicine for no legitimate purpose  
3       to a young adult, and that young adult went on  
4       to have a very serious problem with abuse and  
5       overdose, that they couldn't determine whether  
6       the doctor was substantially liable?

7           A.       Again, I can't speak for most  
8       people. I don't know what they do and don't  
9       believe. That's not my job. And it's not my  
10      purpose here as a fact witness, no.

11       Q.       Could you tell us that they're more  
12      than 10 percent responsible?

13                   MR. GALLUCCI: Object to form.

14                   THE WITNESS: Again, I can't speak  
15      to what other people do and don't believe.  
16      People believe a lot of things. I -- that's  
17      not my job here today.

18                   BY MR. CHEFFO:

19       Q.       Do you believe that doctor would be  
20      more than 10 percent responsible?

21                   MR. GALLUCCI: Object to form.

22                   THE WITNESS: Again, my beliefs  
23      aren't what's...

24                   BY MR. CHEFFO:

25       Q.       No. I'm allowed to ask you your

1       personal beliefs here.

2           A.       Well, you can ask. But I'm here as  
3       a fact witness about my work in the opioid  
4       crisis as a director of operations for the  
5       Medical Examiner's Office.

6           Q.       Right.

7                   And is your -- is your -- your view  
8       that there is a doctor who illegally prescribes  
9       an -- unlawfully a medicine to someone who  
10      ultimately goes on to overdose in this  
11      community, that they are more than 10 percent  
12      liable?

13          A.       I wouldn't put a percentage on it.

14          Q.       Would it be 99 percent?

15          A.       I wouldn't --

16                   MR. GALLUCCI: Object to form.

17                   THE WITNESS: -- put a percentage on  
18      it. I'm telling you I don't know what people  
19      do and don't believe. My beliefs aren't  
20      relevant. My work in the medical examiner's  
21      office is to review this data, to get people  
22      together, to inform them about the crisis, give  
23      them a baseline of data, and try to come up  
24      with solutions.

25                   That's what we've tried to do over

1 the last seven years.

2 Q. Do you draw conclusions from the  
3 data?

4 A. Somebody does. I -- not my job to  
5 draw conclusions. That's for the medical  
6 professionals and the scientific professionals.

7 Q. Do you think you've drawn some  
8 conclusions earlier today when I've asked you  
9 some other questions from the data or --

10 A. Such as?

11 Q. Well, I'm just asking.

12 Have -- don't you think you've drawn  
13 some conclusions when I've asked you questions?

14 MR. GALLUCCI: Object to form.

15 THE WITNESS: I would have to go  
16 back and read. I don't know.

17 BY MR. CHEFFO:

18 Q. Okay. So your view is you don't  
19 draw any conclusions; you just can testify  
20 about conclusions drawn by the department?

21 MR. GALLUCCI: Object to form.

22 THE WITNESS: Well, I believe that's  
23 why I was called to come here. So my personal  
24 beliefs aren't part of that. What I've tried  
25 to do is gather enough people in the room who

1 are experts at these task forces and get them  
2 to have these discussions and try to move as  
3 best we can forward in addressing the crisis.

4 BY MR. CHEFFO:

5 Q. And Mr. -- and just to be fair,  
6 right, I -- I'm not asking you about personal  
7 topics or your beliefs on things that have  
8 nothing to do with this litigation. You've  
9 written e-mails. You've talked about it.

10 So just to be clear, right, I'm only  
11 asking you your beliefs in connection with the  
12 work that you've done in -- in connection with  
13 this case, right?

14 So you -- I think you've told me  
15 you're not --

16 A. Okay.

17 Q. -- going to testify. But I'm -- I'm  
18 not trying to intrude on your personal beliefs  
19 on -- on everything in the -- in the world,  
20 right?

21 You know, you -- you've -- you  
22 participated in many of these things.

23 And I understood that part of being  
24 on the task force and working in your capacity  
25 is that you share information and assessments

1 and beliefs, right?

2 MR. GALLUCCI: Object to form.

3 THE WITNESS: I share data. And I  
4 share what conclusions that the experts have  
5 come up with based on our data.

6 BY MR. CHEFFO:

7 Q. So our -- in my situation or my  
8 hypothetical, are -- you -- you can't really  
9 put a percentage on whether the doctor -- or  
10 how much the doctor might have been  
11 responsible, right?

12 MR. GALLUCCI: Object to form.

13 THE WITNESS: So again, doctors  
14 operate in the environment that they are given.  
15 That is the ultimate responsibility. If they  
16 have other responsibility, the legal system  
17 will ferret that out. That's not our job.

18 BY MR. CHEFFO:

19 Q. Okay. I mean are the -- in the --  
20 in the -- in the hypothetical I gave you, are  
21 the defendants in this case a substantial  
22 cause?

23 Right.

24 I take it you can't tell me those  
25 percentages, could you?

1 MR. GALLUCCI: Object to form.

2 THE WITNESS: The defendants being  
3 your clients.

4 BY MR. CHEFFO:

5 Q. Well, I mean do you know --

6 A. They weren't in the --

7 Q. -- who the defendant --

8 A. They weren't in the hypothetical, so  
9 I didn't --

10 Q. Yeah.

11 In that hypothetical, are they  
12 substantially responsible?

13 A. So again --

14 MR. GALLUCCI: Object to form.

15 THE WITNESS: -- I'm not really -- I  
16 have 3,000 real cases that we can talk about  
17 instead of a hypothetical.

18 BY MR. CHEFFO:

19 Q. Okay. We'll get --

20 A. Largely I would say yes, the  
21 defendants are responsible for creating the  
22 environment that we are all operating in:  
23 overdispensing, overproduction, mass marketing.

24 Q. Okay. So what percentage?

25 A. I don't have --

1 MR. GALLUCCI: Object to form.

2 THE WITNESS: -- percentages either.

3 BY MR. CHEFFO:

4 Q. Is it a hundred percent?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: I would say it's  
7 pretty close to it. They created the  
8 environment that we're operating in.

9 BY MR. CHEFFO:

10 Q. And -- and so any overdose that  
11 occurs from now until when will be a hundred --  
12 or close to a hundred percent responsibility?

13 MR. GALLUCCI: Object to form.

14 THE WITNESS: That's not -- not in  
15 my purview.

16 BY MR. CHEFFO:

17 Q. Well, sir, you know, in fairness you  
18 can't tell me that you have a view on something  
19 and then tell me it's not your job.

20 Do you have a view or not as to  
21 whether the substant -- the -- that the  
22 defendants are substantially responsible?

23 If the answer is no, you don't have  
24 a view, then that's your answer. If it's  
25 something different, then --



1 A. I --

2 Q. -- you should tell me that too.

3 A. I believe --

4 MR. GALLUCCI: Object to form.

5 THE WITNESS: I believe I said yes,  
6 that they are substantially.

7 MR. CHEFFO: Okay.

8 THE WITNESS: And I don't --

9 BY MR. CHEFFO:

10 Q. So --

11 A. -- have a percentage for you. And I  
12 don't know, in perpetuity, how long that  
13 responsibility is going to last. I believe  
14 that's what the lawsuit was all about.

15 Q. Who else is responsible?

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: For  
18 creating overprescribing markets --

19 BY MR. CHEFFO:

20 Q. No. For --

21 A. -- and --

22 Q. -- the opioid --

23 A. -- mass marketing and -- these are  
24 the factors that this community has determined  
25 led to the crisis that we're facing right now.

1 I can't...

2 Q. Who else is -- what other factors  
3 and who else is responsible for the opioid  
4 problem in the county?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: Your -- your clients  
7 created the market. They supplied it,  
8 oversupplied it. They marketed it,  
9 overmarketed it. They used tactics that were  
10 not above board to create the market that we  
11 exist in now --

12 BY MR. CHEFFO:

13 Q. Who --

14 A. -- that led to this crisis.

15 MR. CHEFFO: Okay. Move to strike.

16 THE WITNESS: That's the  
17 contention --

18 BY MR. CHEFFO:

19 Q. Who --

20 A. -- of this community.

21 Q. Who else is responsible?

22 Is anybody else responsible?

23 MR. GALLUCCI: Object to form.

24 THE WITNESS: I think that's been  
25 asked and answered several times --

1 MR. CHEFFO: It has not.

2 THE WITNESS: -- now, so...

3 BY MR. CHEFFO:

4 Q. Who else -- you -- you said the  
5 defendants. And I'm going to go through each  
6 one and find out why. But I want to know if  
7 there's -- who else, if anyone else, is  
8 responsible.

9 MR. GALLUCCI: Object to form.

10 It has been answered many times.

11 He's also --

12 MR. CHEFFO: I don't think so.

13 MR. GALLUCCI: -- told you that he  
14 doesn't have the ability to determine  
15 responsibility about 20 minutes ago when we  
16 started this line of --

17 MR. CHEFFO: Except, when --

18 MR. GALLUCCI: -- questioning.

19 MR. CHEFFO: -- it's the defendants,  
20 he has incredible ability to -- to make  
21 determinations.

22 MR. GALLUCCI: But we keep going  
23 down this same line.

24 MR. CHEFFO: Well, that's what he  
25 keeps --

1 MR. GALLUCCI: It's -- it's your  
2 deposition. You could --

3 MR. CHEFFO: Let's -- let's --

4 MR. GALLUCCI: -- do what you want.  
5 But I'm going to --

6 MR. CHEFFO: I understand.

7 MR. GALLUCCI: -- continue to  
8 object.

9 MR. CHEFFO: That's fine, right?

10 BY MR. CHEFFO:

11 Q. I mean do you have a view as to  
12 substantial responsibility or not in connection  
13 with this?

14 Because if you don't, we can move  
15 on. But if you have a view that it's  
16 substantially the defendants' responsibility,  
17 you should tell me.

18 MR. GALLUCCI: Object to form.

19 THE WITNESS: Can we read it back  
20 and see if --

21 MR. CHEFFO: Sure. Do --

22 THE WITNESS: -- I said that several  
23 times already, that the defendants are  
24 substantially responsible?

25 BY MR. CHEFFO:

1 Q. Okay. And I'm asking you --

2 MR. GALLUCCI: I -- I note an  
3 objection.

4 You can answer his question.

5 THE WITNESS: I think I just did.

6 BY MR. CHEFFO:

7 Q. Who else is --

8 MR. GALLUCCI: But -- but the --

9 BY MR. CHEFFO:

10 Q. Who, if anyone else, is -- is  
11 responsible?

12 MR. GALLUCCI: Let's go back to the  
13 question you asked before I instructed him to  
14 answer.

15 You said does he have a view. I --  
16 I'm just trying to go back to the question that  
17 he didn't get a chance to answer. It is at  
18 11:05:18.

19 MR. CHEFFO: Go ahead. I can't -- I  
20 don't --

21 THE WITNESS: It's --

22 MR. CHEFFO: I can't read it.

23 THE WITNESS: That's the view that  
24 we have all determined, is that your -- the  
25 defendants are responsible for creating the

1           opioid crisis that --

2                       MR. CHEFFO:   Okay.

3                       THE WITNESS:   -- we're facing right  
4           now.

5                       BY MR. CHEFFO:

6           Q.       Is there anyone else?

7           A.       This is what we know right now.

8           Q.       Is there anyone else?

9           A.       I don't believe that's the  
10          contention that we've come up with, no.

11          Q.       I'm not -- are you speaking on  
12          behalf of the -- the county now or yourself?

13          A.       Both.

14                       MR. GALLUCCI:   So objection.

15                       You're here --

16                       BY MR. CHEFFO:

17          Q.       You are now a 30(b)(6)?

18                       MR. GALLUCCI:   -- as a fact witness.  
19          We are not on 30(b)(6).

20                       MR. CHEFFO:   Okay.

21                       BY MR. CHEFFO:

22          Q.       So when you say "we," you're talking  
23          about the county.

24                       So you're speaking on behalf of the  
25          county now or not?

1 MR. GALLUCCI: Objection. He's  
2 speaking as a fact witness, not on behalf of  
3 the county. His --

4 MR. CHEFFO: Okay.

5 MR. GALLUCCI: -- 30(b)(6)  
6 deposition's already been held.

7 MR. CHEFFO: Right. That's what I  
8 thought so too.

9 BY MR. CHEFFO:

10 Q. So other than the defendants, is  
11 anyone else, in your view, responsible for the  
12 opioid crisis in Cuyahoga County today?

13 A. Not if you take it back to the  
14 inception, no.

15 Q. And so drug cartels are not  
16 responsible?

17 A. For creating the market?

18 Q. No. For the opioid crisis that's --  
19 exists today.

20 Are they responsible for that in any  
21 way?

22 A. That's a different question.

23 Q. Okay. Well, that's what I'm talking  
24 about. Let me ask you then differently.

25 Are -- with respect to the opioid

1 crisis that exists in the community today, is  
2 there anyone other than the defendants who you  
3 believe are responsible?

4 A. Not for creating the market that  
5 sets up this --

6 Q. You're not --

7 A. -- crisis.

8 Q. You're -- so you know you're  
9 intentionally not answering my question. I'm  
10 going to keep answer it -- asking the same  
11 question.

12 All right. I asked you very  
13 specifically -- and you can't redefine my  
14 question.

15 I said, with respect to the opioid  
16 crisis today, is there anyone else that you  
17 believe is responsible other than the  
18 defendants?

19 A. But it's not as simple as a snapshot  
20 of today. There are --

21 Q. I get to ask the questions.

22 MR. GALLUCCI: Well, let him finish  
23 his answer. You can certainly follow up.

24 MR. CHEFFO: Okay. I'm going to ask  
25 for more time if we're going to -- if we're not



1 going to answer the question.

2 MR. GALLUCCI: Let -- let's let him  
3 answer the question.

4 MR. CHEFFO: Fine.

5 MR. GALLUCCI: You know, and you're  
6 certainly welcome to. And we feel that you've  
7 gone over the same question --

8 MR. CHEFFO: Well --

9 MR. GALLUCCI: -- many times.  
10 That being said, if you'd like to  
11 answer the question.

12 THE WITNESS: It's not a simple  
13 snapshot. It's not today versus yesterday  
14 versus the year before.

15 It started with the creation of the  
16 environment by overprescribing, overproduction,  
17 mass marketing, direct marketing, pressure  
18 tactics.

19 That is the view that I hold --

20 BY MR. CHEFFO:

21 Q. Okay. And I --

22 A. -- based on what I've learned over  
23 the last seven years and the last 3,000 people  
24 who have died.

25 Q. And you've testified that --

1           A.       That's informed me.

2           Q.       -- to many times.

3                    You've talked about what started --  
4       what you believe started this chain of events,  
5       right?

6           A.       And that's the cause.

7           Q.       Okay. And I'm -- I'm asking what  
8       are the other contributing factors that led to  
9       the opioid crisis as it exists today in  
10      Cuyahoga?

11          A.       So just like the work that our  
12      doctors do, the cause of death is the cause of  
13      death. So people who are in a --

14          Q.       So it's your testimony --

15          A.       -- car accident die because their  
16      head hits the windshield. That's a cause of  
17      death.

18          Q.       Okay. So tell me what --

19          A.       They may have been drinking at the  
20      time. That may have led to the crash  
21      eventually. But the cause of death is the  
22      cause of death.

23                   The cause of this crisis is the work  
24      that your -- the defendants did in saturating  
25      this community and communities across the

1 United States with way too many prescribed  
2 opioids and all the tactics that went with it.

3 Q. Okay. And can you -- can you tie  
4 any conduct or tactic of any defendant to  
5 any -- any overdose death?

6 A. I don't know who all the defendants  
7 are specifically.

8 Q. But yet you're --

9 A. That's not --

10 Q. You couldn't even name them, could  
11 you?

12 MR. GALLUCCI: Well, let him finish  
13 the answer, please.

14 BY MR. CHEFFO:

15 Q. Do you know who the defendants are?

16 A. I don't know every single company  
17 that's listed, no. I could probably check the,  
18 you know, litigation and --

19 Q. Do you have --

20 A. -- and find out, but...

21 Q. Do you have specific information  
22 about the conduct of any defendant?

23 A. That's not part of my job, no.

24 Q. So the answer is no, right?

25 A. That's not part of my job. No, it's

1 not.

2 Q. So do you know -- do you have any  
3 information about let's say -- well, strike  
4 that.

5 Are you -- are you an expert in --  
6 in -- in pharmaceutical marketing?

7 A. I think we've already established  
8 I'm not here as an expert --

9 Q. Right.

10 A. -- on any means.

11 Q. And you don't know -- do you have  
12 any -- any personal knowledge about any  
13 marketing activities of any of the defendants?

14 A. Personal knowledge.

15 Q. Yeah.

16 A. Like did they market me personally?  
17 No.

18 Q. I mean do you have any -- do you --  
19 could you testify with any specificity about  
20 anything anyone did or didn't do?

21 A. Just reports and books that I read  
22 and not test -- and -- not testimony. It's  
23 discussions in the task force.

24 Q. So your knowledge comes from the  
25 task force?

1           A.       Largely informed by the task force  
2           and then the work that we do at the Medical  
3           Examiner's Office, yes.

4           Q.       And have you seen any documents from  
5           any defendant in this case?

6           A.       Can you be more specific? Any  
7           documents? I --

8           Q.       Yeah.

9                    I mean do you recall seeing any --

10          A.       Related to this lawsuit, I've seen  
11          documents that have defendants' names on it.  
12          Yeah, that's...

13          Q.       Have you looked at marketing  
14          campaigns or any other information?

15          A.       That's not part of my job. No, I  
16          haven't.

17          Q.       Have you looked at any distribution  
18          records for any opioids in Cuyahoga County?

19          A.       I don't have access to that. If  
20          we --

21          Q.       Have you --

22          A.       -- did -- that's part of the  
23          problem, but...

24          Q.       Well, you would like to have -- the  
25          problem is what, that you don't have access to

1 distribution?

2 A. Well, I think the problem is -- is  
3 that, if we had seen the distribution patterns  
4 sooner, we might have been able to head off the  
5 problem sooner.

6 Q. Do you know what ARCOS is?

7 A. That's been explained to me that  
8 that's the database that tracks the  
9 distributions.

10 Q. And that would be important  
11 information to look at?

12 A. It could be very helpful.

13 Q. So I take it you've looked at it?

14 A. I have not.

15 Q. It could be very helpful, but you  
16 have not looked at it.

17 A. It's a federal regulated database.  
18 I don't have authorization to have access to  
19 that.

20 Q. Would you be shocked to hear that  
21 your lawyers actually have it in their offices?

22 MR. GALLUCCI: Object to form.

23 THE WITNESS: I don't think anything  
24 would shock me at this point.

25 BY MR. CHEFFO:

1           Q.     But if they had it, you'd certainly  
2     like to see it?

3           A.     Wouldn't be part of my specific job  
4     duties. But I'm sure people who are addressing  
5     this crisis would.

6           Q.     Law enforcement would want to see  
7     it, right?

8                     MR. GALLUCCI: Object to form.

9                     THE WITNESS: I can only speculate.  
10    That's...

11                    BY MR. CHEFFO:

12           Q.     And your speculation would be yes,  
13     right?

14                    MR. GALLUCCI: Object to form.

15                    THE WITNESS: I assume so, yes.

16                    BY MR. CHEFFO:

17           Q.     And do you -- do you have any  
18     information about what -- let's just start with  
19     some of the pharma companies.

20                    Do you have any information about  
21     what any doc -- any pharmaceutical company said  
22     to any prescribing doctor in Cuyahoga County?

23           A.     No personal knowledge, no.

24           Q.     And do you -- have you ever seen any  
25     interviews of any doctor who prescribes opioids

1 as to why they prescribe them?

2 A. I'm sure I've read news stories,  
3 seen documentaries and things like that, yes.

4 Q. Can -- can you tie any specific  
5 prescription to any statement or -- or  
6 falsehood or omission from any of the  
7 defendants in this case?

8 A. Other than the general claim that  
9 they weren't addictive. But I'm not a doctor  
10 or a scientist, and that's really not part of  
11 my job duties, so...

12 Q. Well, and -- and -- have you looked  
13 at the labelling for any of the products?

14 A. No.

15 Q. Would it shock you if it said in  
16 bold that there's a risk of addiction --

17 MR. GALLUCCI: Object to form.

18 BY MR. CHEFFO:

19 Q. -- for opioids?

20 A. Like I said, I don't think anything  
21 would shock me at this point.

22 Q. Well, did you know that?

23 A. I think there's a general  
24 understanding, yeah, that they were eventually  
25 forced to put that label on there.



1 Q. When -- when were they?

2 A. I wouldn't -- I wouldn't be able to  
3 give you a -- a specific date.

4 Q. Well, within the last two years?

5 A. I don't know.

6 Q. Was it in the last ten years?

7 A. I don't know.

8 Q. If -- whenever that was put on, that  
9 would be important, right?

10 If the label actually said that it  
11 was -- there was a risk of addiction, wouldn't  
12 that be important to you?

13 MR. GALLUCCI: Object to form.

14 THE WITNESS: Important to me?

15 MR. CHEFFO: Uh-huh.

16 THE WITNESS: I -- I think it's  
17 important information that should not have been  
18 kept from the public, no.

19 BY MR. CHEFFO:

20 Q. But -- but you don't know if it was  
21 or wasn't kept from the public, do you?

22 A. Well, I know they haven't been on  
23 all the time. I couldn't give you a specific  
24 date. So...

25 Q. But --

1           A.       The warning wasn't on the label all  
2 the time.

3           Q.       For all of the defendants and all  
4 the products, your testimony is it wasn't on  
5 the label?

6                   MR. GALLUCCI: Object to --

7                   BY MR. CHEFFO:

8           Q.       You know that, or are you guessing?

9                   MR. GALLUCCI: Object to form.

10           THE WITNESS: I couldn't tell you a  
11 specific date when the warning about the  
12 addictive nature of opioids was put on  
13 prescription bottles.

14                   BY MR. CHEFFO:

15           Q.       But whenever it was, that would be  
16 an important event because that disclosed  
17 information that you believe should be  
18 disclosed to the public and doctors.

19           A.       Yes.

20           Q.       And -- and if you found out that  
21 that -- it's been on the -- the label for 18  
22 years or more, that would be information that  
23 you would want to know, right?

24                   MR. GALLUCCI: Object to form.

25           THE WITNESS: Like I said, I know --

1 I'm not sure that would better inform my work  
2 on a day-to-day basis, but...

3 BY MR. CHEFFO:

4 Q. But if a doctor -- I mean do -- do  
5 you believe doctors don't know that opioids  
6 have addictive properties?

7 MR. GALLUCCI: Object to form.

8 THE WITNESS: Not now.

9 BY MR. CHEFFO:

10 Q. Real -- have you ever met a doctor  
11 in your life who told you that they didn't  
12 think that opioids had the risk of addiction?

13 A. Well, unfortunately, the doctors  
14 I've been hanging out with lately are the ones  
15 who are trying to treat the crisis. So they're  
16 all very well informed.

17 Q. Right. My question was different.  
18 And I'd just ask if you answer my question and  
19 not give a speech.

20 If -- do -- are you -- have you ever  
21 met a doctor in your life who told you that  
22 they were unaware of the risk of -- of  
23 addiction with opioid medicines?

24 A. I don't recall any conversation with  
25 any doctor that has specifically came up

1 outside of my work with the task force in the  
2 Medical Examiner's Office.

3 Q. Okay. Inside. Any -- any time. My  
4 question's very specific.

5 Did any doctor ever tell you, in  
6 substance -- sum or substance, that he or she  
7 was not aware that there were addictive  
8 properties of opioids?

9 A. Again, I don't think it was ever a  
10 topic of discussion outside of the task force.  
11 I don't know why it would come up. But it  
12 hadn't, no.

13 Q. So in the task force, did any doctor  
14 tell you that, even the doctors who treat  
15 addiction?

16 A. No. I said the doctors that I've  
17 been dealing with in the last seven years  
18 fighting this crisis are very well informed.

19 Q. Right.

20 So -- and do those doctors write  
21 opioid prescriptions?

22 MR. GALLUCCI: Object to form.

23 THE WITNESS: I don't know. I don't  
24 know their basic nature of their practice. I'm  
25 sure some of them do.

1 BY MR. CHEFFO:

2 Q. Right.

3 And if they -- if they wrote a  
4 prescription for an opioid right now, would you  
5 think that that was the responsibility -- the  
6 people on the task force, would you think that  
7 was the responsibility of some improper  
8 influence by a pharmaceutical company?

9 MR. GALLUCCI: Object to form.

10 THE WITNESS: I'm not sure I can --

11 BY MR. CHEFFO:

12 Q. Really?

13 MR. GALLUCCI: Object to form.

14 THE WITNESS: I'm not sure I  
15 understand what you're trying to get me to say  
16 or ask me.

17 BY MR. CHEFFO:

18 Q. I don't think I'm trying to get you  
19 to say anything other than tell the truth.

20 MR. GALLUCCI: I think he's also  
21 saying what's the question.

22 MR. CHEFFO: Okay. And I'll read it  
23 back. I'll -- I'll do it again.

24 BY MR. CHEFFO:

25 Q. You work with doctors on the task

1 force who deal with addiction and opioid --  
2 opioid prescriptions and have some expertise,  
3 right?

4 A. Yes.

5 Q. You trust them?

6 A. For what?

7 Q. Being honorable people who have the  
8 public interest at heart?

9 A. Basically, yes. I don't know them  
10 all that well, each one of them individually,  
11 but...

12 Q. Do you think they're there  
13 advocating positions for manufacturers of  
14 pharmaceuticals or distributors of medicines?

15 A. At the task force?

16 Q. Yes.

17 MR. GALLUCCI: Object to form.

18 THE WITNESS: No. But then I didn't  
19 think Carole was going to do that either. And  
20 she was running the task force at the time,  
21 so --

22 BY MR. CHEFFO:

23 Q. Do -- do you think -- do you think  
24 any of the doctors on the task force are acting  
25 in any at the behest or under the influence of

1 any pharmaceutical company or distributor?

2 A. I don't believe so, no.

3 Q. All right. And you also believe  
4 that some of them still prescribe opioid  
5 medicines, right?

6 A. I would have to --

7 MR. GALLUCCI: Object --

8 THE WITNESS: -- ask them  
9 specifically.

10 BY MR. CHEFFO:

11 Q. But it's your belief --

12 MR. GALLUCCI: Object to form.

13 BY MR. CHEFFO:

14 Q. It's your belief, is -- isn't it?

15 MR. GALLUCCI: Object to form.

16 THE WITNESS: I'm sure there are  
17 some that still do, yes.

18 BY MR. CHEFFO:

19 Q. And if that doctor -- tell me --  
20 tell me the names of the doctors on -- that  
21 you -- that you can recall on this task force,  
22 the ones who might prescribe opioids.

23 A. I think Dr. Pap and Dr. Collins are  
24 in emergency medicine at Metro. So I'm sure  
25 that would come up, but...

1           Q.       Okay. And -- and Dr. Pap and Dr.  
2 Collins you think are on the task force for  
3 altruistic reasons in order to help address  
4 opioid issues?

5           A.       Yes.

6           Q.       And do you believe, when they write  
7 a prescription today or wrote one yesterday,  
8 that they are doing so because they were under  
9 the influence or are under the influence of a  
10 pharmaceutical company?

11          A.       I wouldn't think so. But that's not  
12 rally my place either.

13          Q.       Okay. But the answer -- you -- you  
14 -- you -- that wouldn't be your determination,  
15 would it?

16          A.       No. But my determination doesn't --

17          Q.       Okay. And --

18          A.       -- have a lot of weight.

19          Q.       And you would believe that -- that  
20 they wrote the prescription because they  
21 thought it was medically appropriate for their  
22 patient, right?

23                   MR. GALLUCCI: Object to form.

24                   THE WITNESS: I believe so, yes.

25                   BY MR. CHEFFO:



1           Q.     And did they ever tell you that they  
2     had written prescriptions in the past and said,  
3     in sum or substance, "Oh, my gosh, I wrote a  
4     lot of prescriptions because I was improperly  
5     influenced by distributors of man -- or  
6     manufacturers of pharmaceutical products"?

7           MR. GALLUCCI:   Object to form.

8           THE WITNESS:   I don't think they  
9     discuss their medical prescription.   That would  
10    be a HIPAA violation.   I don't --

11          BY MR. CHEFFO:

12          Q.     Not specifics.

13          A.     -- think they discuss it.

14          Q.     But in this whole task force, did  
15     they say, "In the -- this environment, I want  
16     to just tell you I was subject to this improper  
17     influence"?

18                 Do you remember them saying anything  
19     like that?

20          A.     I haven't had a conversation like  
21     that with anybody at the task force, no.

22          Q.     Okay.

23                 MR. GALLUCCI:   We've been going  
24     for about hour.

25                 Do you want to take a break?

1 MR. CHEFFO: Can I just finish this  
2 for two minutes?

3 MR. GALLUCCI: That's fine.

4 BY MR. CHEFFO:

5 Q. And so, if a prescription was  
6 written by any of these doctors -- these two  
7 doctors for an opioid, would you believe that  
8 it was suspect; or would you believe that,  
9 based on everything you know about them, that  
10 the prescription was written because they made  
11 an appropriate medical determination that it  
12 was in the best interest of their patient?

13 MR. GALLUCCI: Object to form.

14 THE WITNESS: I think you're really  
15 asking me to make suppositions. I'm not really  
16 in any position to make those determinations.

17 BY MR. CHEFFO:

18 Q. Do you have any reason to believe  
19 that the prescription that they right are  
20 somehow in any way connected with improper  
21 conduct by any of the defendants?

22 A. Again, you're asking me to make  
23 supposition.

24 Q. I'm not --

25 A. I have no idea.

1 Q. I'm asking you --

2 A. I don't talk -- discuss their  
3 medical prescribing habits. I don't discuss  
4 medical issues with them outside of the task  
5 force. And that's -- the focus is --

6 Q. You -- you --

7 A. -- the opioid crisis.

8 Q. You've told me a few minutes ago or  
9 told us that you think all of this relates back  
10 to the cause.

11 And I want to say are -- are these  
12 two doctors, if they prescribe opioids, is  
13 that -- are -- are they doing so in any way  
14 connected to anything any of the defendants  
15 did?

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: I don't think what has  
18 happened since the opiate crisis -- it informs  
19 people. Like I said, all the people in this  
20 room are highly informed. So...

21 BY MR. CHEFFO:

22 Q. What does that mean?

23 A. It means that these people are  
24 medical professionals. I don't discuss their  
25 medical professional interactions with patients

1 with them.

2 Q. I understand that.

3 But you -- you've basically told us  
4 that all of the -- so if one of their patients  
5 were to overdose on an opioid that they wrote,  
6 would you think that that was related to the  
7 conduct of the defendants?

8 MR. GALLUCCI: Object to form.

9 THE WITNESS: That's not my job to  
10 determine.

11 BY MR. CHEFFO:

12 Q. Well, would -- would the defendants'  
13 conduct be a substantial cause?

14 MR. GALLUCCI: Object to form.

15 THE WITNESS: I think that's the  
16 issue that's trying to be settled. That's --

17 BY MR. CHEFFO:

18 Q. Well, what do you believe?

19 MR. GALLUCCI: Object to form.

20 THE WITNESS: I don't think that my  
21 suppositions in this case are relevant.

22 BY MR. CHEFFO:

23 Q. Well, you told us earlier that you  
24 believe that all of these prescriptions going  
25 back in time were a substantial cause of

1 manufacturers.

2 Now I've given you some very  
3 specific doctors and facts, and you -- you  
4 don't seem to have the same view.

5 A. I think that's a mix --  
6 mischaracterization --

7 Q. Okay. So --

8 A. -- of my view.

9 Q. -- when they write a prescription  
10 today, yesterday, last year, is it your belief  
11 that every prescription for opioids that they  
12 wrote was as a result of -- a substantial  
13 result of the conduct or actions of the  
14 defendants?

15 MR. GALLUCCI: Object to form.

16 THE WITNESS: So prior to this, we  
17 were talking about people who were dying of  
18 overdoses.

19 MR. CHEFFO: Well --

20 THE WITNESS: Every -- there are  
21 legitimate needs for prescription opioids. I  
22 don't know what they are because I'm not a  
23 doctor.

24 BY MR. CHEFFO:

25 Q. Okay. But if -- so there are

1       legitimate needs.

2                   You would agree with that, right?

3           A.       That is what I've been told. I'm  
4       not a doctor.

5           Q.       And do you believe that -- so do you  
6       -- you would agree with me that -- that not --  
7       the -- the defendants are not responsible for  
8       all -- there's no liability or culpability in  
9       your mind if a doctor writes a prescription for  
10      a legitimate purpose; is that right?

11                   MR. GALLUCCI: Object to form.

12                   THE WITNESS: I don't know all  
13      circumstances that could grow from that. So I  
14      couldn't answer.

15                   BY MR. CHEFFO:

16           Q.       If a doc -- if one of these two  
17      doctors wrote a prescription, and their -- one  
18      of their patients did overdose, would that in  
19      any which be the responsibility of any of the  
20      defendants in this case?

21           A.       That's not --

22                   MR. GALLUCCI: Object to form.

23                   THE WITNESS: -- a determination I  
24      need to make.

25                   MR. GALLUCCI: Give me a moment so

1       that --

2                   THE WITNESS:   Sorry.

3                   MR. GALLUCCI:   -- I can put  
4       objections and we're not talking over each  
5       other.

6                   THE WITNESS:   I'm sorry.

7                   MR. GALLUCCI:   Object to form.

8                   You may answer.

9                   BY MR. CHEFFO:

10           Q.       I'm asking your personal view.

11           A.       I don't think my personal view has  
12       anything to do with it.

13           Q.       Okay.   Do you have a view as to  
14       whether -- if -- if a doctor who you know and  
15       trust, Dr. Pap or Dr. Collins, wrote an opioid  
16       prescription, and one of their patients had a  
17       -- an unfortunate and sad outcome of an  
18       overdose and died, would you think that they  
19       somehow had responsibility; or would you  
20       attribute that to improper conduct of the  
21       defendants?

22           A.       I don't know that I could say.

23                   MR. CHEFFO:   Okay.   Let's take a  
24       break.

25                   MR. CARTER:   Before we go off the

1 record, I just wanted to note something that  
2 came to our attention. I wanted to note it  
3 while it was the first opportunity.

4 I just received information that  
5 plaintiffs made their 89th document production  
6 on MLK day. And in that production that was  
7 just uploaded within the last 24 hours, there  
8 are apparently 8,200 documents from Mr. Shannon  
9 where he's identified as the custodian and  
10 1,500 documents where Dr. Gilson is identified  
11 as the custodian.

12 I don't obviously have the ability  
13 in this deposition to analyze those and compare  
14 them to what's previously been produced. So I  
15 don't know the extent to which there is a  
16 problem. But obviously those numbers concern  
17 me and the fact that we're in the middle of the  
18 deposition.

19 So I just wanted to raise that at  
20 the first opportunity that I was provided with  
21 that information so that counsel can  
22 investigate.

23 Obviously, to the extent there are  
24 documents in that that we -- were not  
25 previously covered in productions, you know, we



1 would have problems in terms of proceeding with  
2 the deposition and as well as reopening Dr.  
3 Gilson's.

4 But I have not had the opportunity  
5 to analyze them, so I don't know one way or the  
6 other. I wanted to flag that at the first  
7 opportunity.

8 MR. GALLUCCI: And during the break,  
9 I'll certainly look into what may have been  
10 produced --

11 MR. CHEFFO: Okay.

12 MR. GALLUCCI: -- if there was  
13 something and try to advise you further.

14 MR. CHEFFO: Thanks, Frank.

15 And -- and I'm not -- that point, I  
16 -- and I'm glad you reminded me, Ed. Thank  
17 you.

18 Just -- we had asked for -- and --  
19 and please tell me if it was produced. Because  
20 it may well have been. But at the deposition  
21 of Dr. Gilson --

22 MR. GALLUCCI: The 30(b) or the  
23 fact?

24 MR. CHEFFO: The fact one on --  
25 what's today?

1 MR. GALLUCCI: Yesterday.

2 MR. CHEFFO: Tuesday.

3 MR. GALLUCCI: Tuesday, was it?

4 MR. CHEFFO: He testified about a  
5 poster board or abstract that had been  
6 submitted. And we asked for it then and ask  
7 for it again. So if it's been produced --  
8 again, lot of paper. I'm not throwing stones  
9 here -- just tell me.

10 If not, I would kind of -- again,  
11 and I think I -- again, I don't want to get off  
12 -- talk too much on the record -- but think Sal  
13 indicated that he was going to be looking for  
14 it, if he -- if he could find it.

15 MR. GALLUCCI: So I'll certainly get  
16 you an update. But to be clear, that was some  
17 time -- that happened Tuesday, and it's now  
18 Thursday.

19 So your request was Tuesday. You  
20 want me to follow up on that, correct?

21 MR. CHEFFO: Yeah. I made the  
22 request on the record, then informally after.

23 MR. GALLUCCI: Fair enough.

24 MR. CHEFFO: And he just said -- you  
25 know, and I know there's a lot of paper

1 floating around. So if you could just find out  
2 if it's been produced; and if not, where it is  
3 in the chain.

4 MR. GALLUCCI: Sure. Thank you.

5 THE VIDEOGRAPHER: We are going off  
6 the record.

7 This is the end of Media Unit No. 2.

8 The time is 11:28.

9 (A short recess was taken.)

10 THE VIDEOGRAPHER: We are going back  
11 on the record.

12 This is the start of Media Unit No.  
13 3.

14 The time is 11:49.

15 MR. GALLUCCI: And, Counsel, just  
16 for further update, during the break I did look  
17 into production No. 89, which you inquired  
18 about. And I don't know if it was from the  
19 instructions from the court the -- during the  
20 discovery conference the week of 7th or 14th,  
21 but we had been asked to immediately get out  
22 any and all documents that we no longer  
23 believed were subject to privilege, in a review  
24 of the privilege log.

25 So that's a review of the privilege

1 log after we had further instruction from the  
2 court. And that's why you see multiple  
3 custodians in a single production.

4 As far as -- I believe there was a  
5 request, Mr. Cheffo, with regards to the  
6 abstract that you asked Dr. Gilson about on  
7 Tuesday. I am still waiting for a response as  
8 far as that but will let you know as soon as I  
9 do.

10 MR. CHEFFO: Got it. Okay. Thank  
11 you for the update.

12 MR. CARTER: So to the extent there  
13 were unresolved documents previously as a  
14 result of privilege, it's your understanding  
15 that those would not be duplicative of anything  
16 we had before because they had all been  
17 previously held under privilege?

18 MR. GALLUCCI: I don't know with  
19 specificity the documents that were produced.  
20 All I can tell you is that production No. 89  
21 was a roll-out of a rereview of the privilege  
22 log with the further guidance that we had  
23 received from Judge Polster across the  
24 litigation.

25 MR. CHEFFO: Frank, we should -- is

1       that --

2                   MR. GALLUCCI: Do you want me to --

3                   MR. CHEFFO: No. I -- for the folks  
4       on the phone, we just had a little bit of  
5       colloquy about an update from Frank on the  
6       documents. And you -- hopefully you're seeing  
7       it on your -- your screen there.

8                   But let -- let's just move on, I  
9       mean other than to say, Frank -- and now's not  
10      the time. I mean we obviously appreciate your  
11      efforts in -- in looking at it.

12                   We reserve our rights and need the  
13      chance to look at it. But I know that won't  
14      surprise you.

15                   BY MR. CHEFFO:

16               Q.     You ready to go again?

17               A.     Yes, sir.

18               Q.     Okay. So what is your role on the  
19      -- well, strike that.

20                   There are two task force, right?

21                   There's U.S. Attorney's task force,  
22      and then there's the Board of Health task  
23      force, right?

24               A.     Correct.

25               Q.     You have some involvement with the

1 Board of Health task force but not the U.S.

2 Attorney task force; is that right?

3 A. No.

4 Q. Okay.

5 A. It's the other way around.

6 Q. Oh.

7 A. I sit on the U.S. Attorney's task  
8 force for our office. Dr. Gilson attends the  
9 one for the Board of Health.

10 Q. I see. Sorry. Thank you for the  
11 clarification.

12 And what is your role on the U.S.  
13 Attorney's task force?

14 A. So I report out data from the  
15 Medical Examiner's Office. I also am now  
16 chairing the data subcommittee. There were a  
17 number of federal grants that have been awarded  
18 that have to do with getting more specificity  
19 in the data and required a task -- or a  
20 committee to be set up.

21 We had already begun to set one up  
22 in anticipation of the summit that we held at  
23 the end of last year. It was a five-year  
24 return summit. So they asked me to chair that.

25 Q. And when you say "data," is that

1 data just from the medical examiner's  
2 department, or is it data across various  
3 agencies and entities?

4 A. So it will include data from a broad  
5 spectrum. The main task is making it more  
6 readily available to make it more realtime  
7 as -- as it's possible.

8 And currently it sits and -- it  
9 rests in different agencies under different  
10 laws of, you know, availability and in a  
11 variety of formats and programs. And there's  
12 no real common platform with which to share it  
13 all on.

14 And so part of the task is -- is try  
15 to come up with a solution that would allow at  
16 least the people who are involved in addressing  
17 the crisis to be able to have access to as  
18 accurate and as near realtime data as possible.

19 Q. And can you tell us what type of  
20 data you will -- you're attempting to make  
21 accessible and why it's important to have that  
22 data as realtime as possible?

23 A. So we're in the process of  
24 identifying specific sources and specific data  
25 streams that currently exist in what formats.

1       So we're kind of surveying the community.

2               Some of it includes obviously  
3       emergency room visits. The Ohio Department of  
4       Health has a program called EpiCenter that is  
5       supposed to track when people are admitted to  
6       an emergency room for an overdose -- for an  
7       opioid overdose.

8               Obviously all the local data on --  
9       that's EMS. So when they're out in the field,  
10      if they administer Naloxone because of a  
11      suspected overdose, there's a stream of data  
12      there.

13              Oftentimes it's not done, again, in  
14      realtime. We get reports from the state's  
15      database like a quarter after the fact. And  
16      it's only done at -- at the ZIP code level.

17              So trying to find more specificity  
18      and, again, trying to get it in more realtime  
19      would be available.

20              Q.     Can I just ask you -- and I don't  
21      want -- I'm sorry. I didn't mean to interrupt,  
22      but I just want to see if I can just clarify.

23              What is kind of the -- the -- the  
24      overarching theme, if you will, of the type of  
25      data -- like you're not just trying collect all



1 data ever created, right?

2 You're -- you know, when you say,  
3 "We're trying to figure out the sources,"  
4 what's the hypothesis?

5 What's the question you're trying to  
6 ask as to where you would search for data?

7 MR. GALLUCCI: Object to form.

8 BY MR. CHEFFO:

9 Q. Do you understand my question?

10 A. Yes.

11 Q. Okay.

12 A. So again, the way that the -- the  
13 way that we operate now, while it's far, you  
14 know, more nimble than it was say seven years  
15 ago, it's still, you know, not always all in  
16 realtime or as near realtime.

17 Because it -- as -- as an overdose  
18 unfolds, as cases unfold, whether they're fatal  
19 or nonfatal, information becomes available at  
20 different points in time. So there's a  
21 continuum that needs to be followed.

22 A -- many different agencies touch  
23 that continuum at different points. And being  
24 able to map that out in its completeness is --  
25 will help inform, you know, what is available,

1       what is important.

2               The overall -- again, aside from the  
3       grant requirements, which -- you know, Case is  
4       administrating -- Case Western Reserve is  
5       administrating that grant. And they would be  
6       able to speak more specifically to the grant  
7       outcomes.

8               But in addition to those  
9       responsibilities, we're trying to build a  
10      platform that will allow accurate, near  
11      realtime data to inform all the responses that  
12      need to take place when an overdose occurs in  
13      Cuyahoga County --

14      Q.      And that --

15      A.      -- either fatal or nonfatal.

16      Q.      Okay. And that -- that's what I'm  
17      -- so is it -- it's -- it's a U.S. Attorney's  
18      task force, but is it only for law enforcement  
19      purposes or prosecution?

20              It sounds like it's broader than  
21      that.

22      A.      It is. So the -- the U.S.  
23      Attorney's task force was set up initially very  
24      broadly, understanding that this was a crisis  
25      that needed to be addressed in a variety of

1       ways, in variety of areas of expertise. Law  
2       enforcement was one piece -- law enforcement  
3       and prosecution, the health policy, the data,  
4       prevention and education, the treatment and  
5       recovery.

6               So bringing together, again, all  
7       those professionals from a variety of  
8       agencies -- and, in many cases, didn't have a  
9       lot of contact with each other before -- before  
10      then --

11             Q.       So -- so is --

12             A.       -- as important.

13             Q.       -- is the goal then of this data  
14      collection -- or the -- or one of the goals to  
15      try to get a broad spectrum of information that  
16      will inform the activities of those variants --  
17      components?

18               So in other words, if you get data  
19      that tells you where there's a law enforcement  
20      need, they could on it. If you get the data,  
21      and it might inform public policy or allocation  
22      of resources, that's another area. If you get  
23      data that could help perhaps focus EMS's  
24      activities, that would be useful.

25               Is that -- is that a fair

1       characterization?

2                   MR. GALLUCCI: Object to form.

3                   THE WITNESS: I think that's  
4       certainly part of it. Again, there are things  
5       that the grant is going to ask to be done that  
6       are longer term. I -- so we have short-term  
7       and long-term goals both.

8                   I think, in the immediate -- the  
9       immediate need is in -- in the initial -- in  
10      the initial response period after an overdose  
11      occurs. Again, it's slightly different when  
12      there's a fatality, whether it happens in the  
13      field or at a hospital.

14                  But being able to inform the  
15      response is kind of the primary short-term goal  
16      and to do that in a more near realtime way.

17                  We're also reaching out to all of  
18      those other task force subcommittees to ask  
19      them, you know, "You've been talking about this  
20      for five years. You know what data you have  
21      now. Where is it? What do you want that you  
22      don't have? What do you have now that can be  
23      improved on?"

24                  So kind of surveying all of those --  
25      all those subcommittees about what their data

1 needs may be and -- and to better inform us  
2 about what exists and what improvements  
3 they think --

4 Q. So --

5 A. -- need to be made.

6 Q. -- so -- so currently what are  
7 the -- the sources or database of information  
8 that your committee that you chair has  
9 identified as being subject to review or  
10 mining?

11 A. Well, that process is underway now.  
12 So we don't -- we haven't compiled a complete  
13 list yet.

14 Q. Do you have any list?

15 Who's on the list currently?

16 A. Well, as I said, so EpiCenter is the  
17 database from the Board of Health. The data  
18 that the Medical Examiner's Office collects on  
19 fatalities, especially at the scene -- we issue  
20 a -- a text or an e-mail alert to certain  
21 investigators in the community so that, when a  
22 fatality occurs, and our investigator, either  
23 by the report or when they get on scene, have  
24 significant indications of -- of drug use,  
25 we're able to inform the investigators to

1       respond.

2               Previously, if we had a suspected  
3       overdose, we would have to wait until some  
4       toxicology had been done, at least the  
5       preliminary toxicology, to give them some  
6       indication about whether it was, you know,  
7       related to drugs or not.

8               And they weren't always all that  
9       obvious at the scene. And so waiting for  
10      toxicology would -- sometimes takes weeks. And  
11      in an investigative situation, time is kind of  
12      the essence.

13              Again, the EMS run reports about  
14      where they're going, when they're administering  
15      Naloxone, where their -- where their pickup  
16      was, where -- what hospitals they may have  
17      taken them to.

18              Some of that data is important to be  
19      able to inform maybe certain areas, like you  
20      were saying, so you can stage EMS units in a  
21      different way, that they'll be able to respond  
22      quicker.

23              Because, especially in the field,  
24      when there's an overdose, time, again, is of  
25      the essence to be able to get there in time to

1 administer Naloxone.

2 We do take data from Project DAWN.  
3 Project DAWN's run out of MetroHealth. It  
4 provides free Naloxone kits to be able to give  
5 to people who have addictions so that they're  
6 able -- and then they're trained on how to  
7 using them so they're able to have the  
8 antidote --

9 Q. Uh-huh.

10 A. -- close by.

11 Q. What about OARRS?

12 A. It's kind of a harm-reduction --

13 Q. Sorry.

14 A. -- a -- a harm-reduction method.  
15 OARRS is one.

16 Q. And ADAMHS?

17 A. So the ADAMHS Board provides  
18 information about people who may have had  
19 treatment. That's more in a long-term -- a  
20 longer-term review. It's not -- the initial  
21 response may not -- may not be better informed.  
22 But it's possible, if they've have already got  
23 somebody in the -- in their database, that they  
24 can look up the histories.

25 That might become more relevant as

1 the quick response teams become more robust.  
2 They're piloting that now. So essentially,  
3 when there's an overdose, the -- they're able  
4 to send people out in the field with law  
5 enforcement to do assessments, answer any  
6 questions about treatment, and try to take  
7 those people and put them into treatment when  
8 they're -- when they're able to.

9 Some of the treatment facilities  
10 have set aside beds specifically for this so  
11 that there's not a long wait. Again, the  
12 longer you have to wait after an overdose  
13 before you get treatment can have an impact on  
14 your recovery.

15 Q. So I think this was separate, but  
16 tell me if I'm right.

17 You -- you -- we talked earlier  
18 about certain analysis of data. I think you  
19 said it was 2012, '13, '14. And then there was  
20 a period of time where that was put on hold --  
21 my words, not yours. But essentially you  
22 didn't continue it because of resource issues.

23 Is that -- did I get that right?

24 A. So the -- the -- the issue became in  
25 2016 the -- fentanyl kind of exploded on the --



1 on the county and doubled the number of total  
2 deaths in the county. So it did -- it did tax  
3 the system, the Medical Examiner's Office.

4 So it was -- it was much more  
5 difficult to do that in a timely basis.  
6 Priorities became, you know, kind of our  
7 day-to-day operations.

8 Q. And but -- I'm sorry.

9 Were you done?

10 A. Well, I -- it's just there is a  
11 laundry list of things that needed to be  
12 done --

13 Q. Uh-huh.

14 A. -- from basically the end of 2015  
15 for the next three years or so. Purchasing new  
16 equipment. Again, the crisis was evolving.  
17 Fentanyl. Fentanyl analogs. Being able to  
18 detect some of these drugs was -- you need a  
19 standard in the laboratory --

20 Q. Uh-huh.

21 A. -- to be able to compare it to -- on  
22 the GCMS --

23 Q. Okay.

24 A. -- the gas chromatographs that are  
25 used to analyze substances.

1                   Carfentanil. That was another one  
2                   that basically couldn't be seen initially. You  
3                   have to set the machines up with the standards  
4                   to be able to detect --

5                   Q.       Uh-huh.

6                   A.       -- in advance.

7                   Q.       And I'm going to ask you some  
8                   specific questions about the processes?

9                   A.       Sure.

10                  Q.       But I'd just like to just -- from a  
11                  factual perspective, it sounds like at some  
12                  point recently or -- strike that.

13                  At some point you were able to  
14                  resume activities in looking at data from 2016  
15                  to the present as you had done back in 2012,  
16                  '13, '14.

17                  Is that fair?

18                  A.       Yes. That's kind of underway now.

19                  Q.       When did that start up again?

20                  A.       I mean we had started work on 2015's  
21                  data when, you know, we kind of got swamped in  
22                  2016. There were some -- there were some  
23                  efforts underway in 2017 and '18. We had some  
24                  public health students -- actually a public  
25                  health student helped with the initial reviews

1 as part of her work at -- at Case. Kind of got  
2 the ball rolling when we were doing poison  
3 death reviews. That continued in '17 and then  
4 in '18.

5 Q. So it didn't --

6 A. To be --

7 Q. -- stop; it just -- it was --

8 A. It --

9 Q. -- a slow process because you had  
10 more cases?

11 A. Yeah. It slowed significantly.

12 And then, again, having extra hands  
13 on deck made it, again, feasible to kind of  
14 continue at a -- at a quicker pace.

15 Q. And now you're back up to where you  
16 want to be?

17 A. I would say that we're getting  
18 close. If we are able to get out, you know,  
19 later this year, '15, '16 and '17 data. We'll  
20 have to start work on last year's data when all  
21 the cases are finally ruled on.

22 And we're trying to set up a system  
23 where these kind of reviews happen as we go in  
24 2019, so it's kind of a dual track, so that we  
25 don't ever get to the point where we're --

1 we're having to play catch-up.

2 Q. Is the goal to -- to wait and hold  
3 '15, '16 and '17 until they're all done; or are  
4 you going to produced them to the public or put  
5 them on your web site after each year is done?

6 A. Well, they're -- they're kind of  
7 being done -- some work, as I think I mentioned  
8 previously, we had done snapshots of like  
9 February of 2017. So some of that data was  
10 collected the -- I think the -- the one project  
11 focused only on fentanyl and not the rest of  
12 the opiates. So we have to go back and get  
13 those.

14 So we have chunks of information in  
15 each year. I think we did a comparison of the  
16 first trimester of '15 and '16 as we were going  
17 through 2016. So I think they'll all be  
18 completed around the same time. I'm not sure,  
19 you know, exactly where we are with each year.  
20 I --

21 Q. Is there any --

22 A. I'd have to --

23 Q. -- reason why --

24 A. -- go and check.

25 Q. -- you wouldn't just finish '15,

1       since it's old, and get that done?

2           A.       Well, it's more, at this point, a  
3       matter of -- the data's collected. It's  
4       putting it -- we developed a new database so  
5       that we can do this kind of in realtime, like I  
6       said, for the 2019 cases. But we're putting  
7       all the old data in.

8           Q.       Uh-huh.

9           A.       So it's not a matter of collecting  
10      the data. It's more of the analysis. And  
11      then, like I said, we already have kind of big  
12      chunks of '16 and '17. I just don't know  
13      specifically what's being worked on at the  
14      moment.

15          Q.       Do you have a time frame as to when  
16      '15, '16 and '17 will be produced?

17          A.       I think I said sometime later this  
18      year. I'm -- I'm hoping mid year maybe. But  
19      it may be delayed. I don't know.

20          Q.       Is any factor that the data may not  
21      help the litigation?

22                   Is that a factor that's being  
23      considered?

24                   MR. GALLUCCI: Object to form.

25                   THE WITNESS: Not in our office, no.

1 BY MR. CHEFFO:

2 Q. You're not aware of any discussions  
3 about the impact of the litigation and timing?

4 MR. GALLUCCI: Object --

5 THE WITNESS: No.

6 MR. GALLUCCI: -- to form.

7 BY MR. CHEFFO:

8 Q. So it's your testimony it's just a  
9 -- a -- it's just been a resource issue, but  
10 you feel like you're at a point where that data  
11 should be produced in the next three, four,  
12 five months?

13 MR. GALLUCCI: Objection.

14 THE WITNESS: I would say mid year  
15 is kind of our -- our target right now, but...

16 BY MR. CHEFFO:

17 Q. In -- let me just ask you some --  
18 some broad questions. You -- you obviously  
19 have a very detailed knowledge of a lot of this  
20 being around it.

21 But first question is I looked  
22 through some of the annual reports, and it's  
23 got a lot of information and data, right,  
24 broken out into -- into a lot of different  
25 ways.

1                   But I wasn't able to find -- and  
2                   maybe because I missed it.

3                   But is there anywhere that shows the  
4                   overall kind of workload going back five or ten  
5                   years, not just specific to accidents or  
6                   homicides, but basically, you know, something  
7                   that says here's how many deaths, here's how  
8                   many that we took in our department, and here's  
9                   how many autopsies?

10                  A.       Overall caseloads?

11                  Q.       Right.

12                  A.       That -- that data is in the stat --  
13                  stat books, yeah.

14                  Q.       Okay. I'm going to probably put it  
15                  in front of you, and you probably could find it  
16                  easier than I am.

17                  But is -- is your sense of overall  
18                  caseloads, what -- what has that been for the  
19                  last ten years?

20                  In other words, have they been --  
21                  has the line looked pretty straight? Has there  
22                  been a dramatic uptick or downtick?

23                  A.       My focus obviously has been in the  
24                  last seven years since I've been there. It's  
25                  definitely been on a steady uptick with some

1 dramatic changes, especially in 2016.

2 I would have to go back and look  
3 previously.

4 Q. Of overall cases?

5 A. Yes.

6 Q. And does that include autopsies?

7 A. So it will. Not every case that  
8 gets reported to the Medical Examiner's Office  
9 is a case that we accept jurisdiction on. We  
10 have statutory kind of outlines that tell what  
11 is and is not a jurisdictional case.

12 Every case that we do accept  
13 jurisdiction on, they don't necessarily get  
14 autopsied. So you'll probably have a number in  
15 there of jurisdictional cases and then  
16 autopsies. The autopsies are a subset of the  
17 jurisdictional cases.

18 Q. Okay. And I think I understand, but  
19 so the record is clear.

20 It sounds like a case is when  
21 someone dies in the jurisdiction, right?

22 Is that what --

23 A. So I apologize. I probably  
24 shouldn't have used that word.

25 So jurisdictional doesn't



1 necessarily mean geographic. All of our cases  
2 are -- all of our -- what we determine as cases  
3 under the jurisdiction of the Medical  
4 Examiner's Office are determine by statute.

5 Violence, trauma, when -- you know,  
6 obviously children, those cases are all  
7 mandatorily reportable to our office.

8 And then to determine whether or not  
9 the office accepts jurisdiction is determined  
10 on previous medical care, whether or not  
11 there's a doctor or -- that has been treating a  
12 parent and who's willing to sign a death  
13 certificate. Or simply if -- you know, if it's  
14 a homicide, it comes. It doesn't matter.  
15 Suicide --

16 Q. Right.

17 A. -- are the same way. Now drug  
18 overdoses, falls.

19 So that's what I meant by  
20 jurisdiction.

21 Q. Okay.

22 A. All the cases that we do accept  
23 jurisdiction of are within the jurisdiction of  
24 Cuyahoga County.

25 Q. Understood. And thanks for that --

1           A.     Did it --

2           Q.     -- clarification.

3                    So -- yeah.   So just to -- to  
4   restate it because I think I understand.

5                    So there -- not every death is  
6   within your jurisdiction, but there are certain  
7   cases that are technically within your  
8   jurisdiction, of which you don't assume -- you  
9   don't take the case.

10                   Like, for example, it might be a  
11   situation where someone who's 95 years old, who  
12   passes away in a hospital, and the attending  
13   doctor is willing to sign, you know, the death  
14   certificate, and there's no question about  
15   improper or unfair play, right?

16                   That might be one where you might  
17   have jurisdiction, but you don't take the case;  
18   is --

19           A.     Correct.

20           Q.     Is that right?

21                   And then, of -- of the subset of  
22   cases that you take the case, a determination  
23   is made based on the circumstances about  
24   whether you're going to do an autopsy.

25           A.     Correct.

1           Q.     Okay. And for the last -- let's --  
2     let's use seven years, you know, since -- I  
3     don't want to be unfair and ask you about stuff  
4     before your time.

5                     For the last seven years, what does  
6     the line look like of cases for which you --  
7     you took, where you took the case where you had  
8     jurisdiction?

9           A.     It's, like I said, a steady kind of  
10    increase year to year with kind of a  
11    substantial jump in 2016 and '17. And then,  
12    you know, it's kind of leveled off since then.

13          Q.     Well, has it leveled off or  
14    substantially dropped in '18?

15          A.     The cases in jurisdiction I'm --  
16    we're still compiling, you know, the 2018 data.  
17    So -- I know that there's a -- there's a drop.  
18    I'm just not sure how big it's going to be yet.

19          Q.     Didn't you do a press release on  
20    this like a few weeks ago?

21          A.     I don't believe so. We did a --

22          Q.     No press conference about a  
23    20-something percent drop?

24          A.     Of our overall caseloads?

25          Q.     Am I getting that -- did you do a

1 press release on -- on drop, or was that only  
2 related to overdose deaths?

3 A. That was -- yeah. That was related  
4 specifically to the overdose deaths,  
5 opioid-related.

6 Q. And what was -- what was the sum and  
7 substance of the -- of the press release in  
8 terms of the statistics?

9 MR. GALLUCCI: Object to form.

10 THE WITNESS: That not all the cases  
11 are ruled on. So this is preliminary data. We  
12 have indications that there is a significant  
13 drop in overall drug deaths in 2018 as well as  
14 opioid-related deaths to the tune of maybe 20  
15 percent, yes.

16 Q. And -- and did -- was there any  
17 reason or factors that were cited as to -- as  
18 the basis of those -- of that drop?

19 A. If I remember correctly, there were  
20 -- there was no one specific thing that anyone  
21 pointed to. I believe that there were a number  
22 -- you know, the ongoing efforts of a number of  
23 agencies contributed.

24 Q. Was that in -- I don't recall the  
25 press release. I think it was referenced.

1 But was it in the press release?

2 Can I go look at -- are the factors  
3 articulated, or do you have knowledge outside  
4 the press release as to what the department  
5 determined were the factors that were at least  
6 partially responsible for the drop?

7 A. I believe there were some bullet  
8 points that were included. I would have to go  
9 back and get the press release to enumerate  
10 them specifically.

11 I think the one thing that we did  
12 determine was that there was a noticeable  
13 absence of carfentanil in the second half of  
14 2018. Carfentanil had driven a lot of deaths  
15 in 2017 over the summer, almost 200.

16 That drug basically vanished from  
17 the local supply I believe after June 1st of  
18 last year. So that was a significant drop.

19 Q. Okay.

20 A. I would have to go back and look at  
21 some of the others. I know that that was one  
22 that they had determined was probably -- and  
23 that -- that was due in some part to the DEA's  
24 efforts in China, getting the Chinese to  
25 regulate carfentanil, which had not been done

1 previous to that. And I think they set up an  
2 office, the DEA did, in China to help with  
3 interdictions.

4 A lot of it was shipped by mail.  
5 And the senate had -- Senator Portman here from  
6 Ohio had sponsored a stop bill, which was  
7 helping get technology into -- into postal  
8 facilities to try to detect drugs before they  
9 got out into the -- kind of the flow of the  
10 mail system.

11 Q. And these were -- these were  
12 largely, if not exclusively, illegal sales,  
13 right?

14 It wasn't someone doing an online  
15 prescription service.

16 A. Not a prescription service, no. A  
17 lot of this was orderable in the dark net  
18 online. But yeah, I...

19 Q. Now --

20 MR. CHEFFO: Can we mark one of  
21 these?

22 BY MR. CHEFFO:

23 Q. What -- what -- what would help you  
24 -- I have these -- like a 2017 thick kind of  
25 Cuyahona [sic] County -- Cuyahoga County

1 report.

2 Is -- is that where you could tell  
3 year over year look-back as to what the number  
4 of cases?

5 A. If -- if I see it, yeah, I can  
6 probably --

7 Q. Okay. We'll mark that in a minute.  
8 We'll come back to it. I just want to give you  
9 what, you know --

10 A. Sure.

11 Q. -- would be fair that -- so you're  
12 not memorizing, you know, numbers that you  
13 probably don't know.

14 But before that, let me just ask you  
15 a -- a few questions about budgets.

16 Do you have responsibilities for the  
17 budget in the department in some respects?

18 A. I do.

19 Q. And what is -- what are your  
20 responsibilities?

21 A. Well, I with work with the budget  
22 office to set, you know, kind of that biannual  
23 budget. We look back at kind of past spending,  
24 past needs to determine if that's a trend  
25 that's going to continue, is it going to

1       increase, is it going to decrease.

2               We have to respond at times when  
3       there are requests for budget cuts. And there  
4       are times when we have to determine if there  
5       are needs outside of our -- what they give us  
6       as kind of the starting budget, the baseline.  
7       If there are going to be needs that were not  
8       contacted for at the beginning of the budget  
9       process.

10              Again, biannual budget means it's a  
11       two-year cycle. Obviously things change over  
12       24 months. And so we'll do a review at  
13       midyear, make adjustments, things like that,  
14       make requests.

15              Q.       So is -- when you say the budget  
16       office, is that an office of the -- the county,  
17       or is that an office within your own  
18       department?

19              A.       No. That's Cuyahoga County's office  
20       of budget and management.

21              Q.       Okay. And?

22              A.       Or budget and management. I --

23              Q.       And of -- of the funding for the  
24       office, the department -- I -- I can use those  
25       interchangeable, right?



1           A.       Yes.

2           Q.       Okay. Of the funding that the  
3 office of the medical examiner receives, does  
4 it all come from the county, or does it come  
5 from other sources, including federal grants or  
6 something else?

7                   MR. GALLUCCI: Object to form.

8                   THE WITNESS: There are other source  
9 outside of the general fund at Cuyahoga County.

10                  BY MR. CHEFFO:

11           Q.       Okay. So tell us what percentage of  
12 the funding for the work that's done by the  
13 Office of the Medical Examiner comes from the  
14 county.

15           A.       So our budget is broken up into  
16 three pots essentially. So our general  
17 operating budget is all general fund, and its  
18 funded fully by the -- the county. It accounts  
19 for about half of the operation, maybe  
20 \$6 million or so.

21                   The forensic lab gets general fund  
22 money as well, but we also have other sources  
23 coming in. Some of that is intergovernmental  
24 agreements to do testing, forensic testing,  
25 specifically with the City of Cleveland.

1                   The grants are kind of kept  
2                   separate. They're administered by the  
3                   Department of Public Safety and Justice  
4                   Services. Because they have a grant writing  
5                   team that -- that we work with. So that's not  
6                   technically on our budget, but it's fund that  
7                   we have available to us.

8                   The DNA backlog grant, for instance,  
9                   Coverdell, allows us to buy equipment. It  
10                  allows us to buy supplies. The DNA grant  
11                  specifically is to make sure that we don't get  
12                  too far behind with a -- a large backlog of  
13                  cases.

14                Q.       Uh-huh.

15                   And can I just ask -- if you could  
16                   just help us differentiate.

17                   Is -- you talked about the two  
18                   separate ones. Your general operate for the  
19                   medical examiner. Then there's the forensic  
20                   lab.

21                   Does the forensic lab have any  
22                   interaction in connection with drug overdose  
23                   cases?

24                   Because if it doesn't, I may not  
25                   want to ask you as much about those questions.

1           A.       Yeah, they do.

2           Q.       What do they -- is that in the  
3 toxicology area?

4           A.       So toxicology is one. The drug  
5 chemistry laboratory is another. DNA actually  
6 has a role to play. There have been, as the  
7 crisis has grown, more and more requests for  
8 DNA on drug packaging. Same with fingerprints.

9                   There are associated crimes, more  
10 drug trafficking, more violence, more  
11 homicides, more gun deaths. So the firearms  
12 unit is impacted as well.

13                   In essence, we've seen just a  
14 general rise in caseloads across most of the  
15 forensic laboratories.

16           Q.       And the -- the DNA on the packaging  
17 I take it is to try and identify a fingerprint  
18 or some other type of DNA source so they can  
19 figure out who handled the packaging, perhaps  
20 sold it or prepared it?

21                   MR. GALLUCCI: Object to form.

22                   THE WITNESS: Sorry.

23                   So fingerprinting is separate from  
24 DNA.

25                   MR. CHEFFO: Okay.

1                   THE WITNESS: It's usually DNA  
2                   because it's more specific. If it -- if it's  
3                   there, it's there. And -- and they're able to  
4                   create the profiles and -- and upload them into  
5                   the databases to check.

6                   BY MR. CHEFFO:

7                   Q. Right.

8                   But --

9                   A. But --

10                  Q. -- the point is, right, to try and  
11                  find out who was involved in the chain of  
12                  this -- if it's an illegal drug, finding out if  
13                  they could identify the person through DNA?

14                  A. Right. That's what I was getting  
15                  to. So there's a -- there's a federal database  
16                  that collects these profiles. And we're able  
17                  to match them with any known profiles that are  
18                  in those databases.

19                  Q. And what happens if there's a  
20                  positive detection of DNA, for example, on drug  
21                  packaging that was found at the scene of an  
22                  overdose death?

23                  A. Those reports will go to the  
24                  investigating agencies for their use.

25                  Q. Okay. And so let's -- let's -- I

1       just want to see if we can, big picture, do  
2       funding, if there's other documents that are  
3       more specific. I think some of them have been  
4       produced. But let's see if I can get a big  
5       picture.

6               So drug lab is one aspect.

7               And you have a \$6 million -- or --  
8       or I'm sorry. It sounds like you have about a  
9       \$12 million budget for what?

10              What's the other half?

11             A.     So -- and that's what I was getting  
12       at. So I talked about the general operating  
13       budget, the forensic lab budget.

14              We also have what we call the  
15       medical examiner's lab fund. That's a  
16       statutory creation. It's mainly funded through  
17       work that we do for other jurisdictions,  
18       autopsy work for surrounding counties, where we  
19       have the facilities and the resources that  
20       other smaller jurisdictions may not have. When  
21       they have a need, we'll do those -- we'll do  
22       those autopsies on their behalf.

23              That -- that money goes into that  
24       fund in case we need to replace equipment as  
25       well.

1           Q.     So is that a profit center when you  
2     do autopsies for other counties?

3           A.     No.

4           Q.     Is that --

5           A.     Statutorily we're not allowed to  
6     charge more than what it costs. And in many  
7     cases, we're not charging, I believe, the true  
8     costs.

9                     Basically because these smaller  
10    jurisdictions are cash strapped as well. And  
11    the crisis is affect everybody, but smaller  
12    jurisdictions to a greater extent. And we've  
13    tried to be helpful --

14          Q.     Right.

15                 So --

16          A.     -- to them.

17          Q.     So when you -- when you don't do an  
18    autopsy for a smaller jurisdiction -- and I  
19    know you probably don't look at it this likely.

20                     But if you're looking at it from  
21    just an economic perspective, that's actually a  
22    net benefit economically, right, because it  
23    actually costs you more to do it, and under the  
24    statute you can't make a profit, right?

25                 MR. GALLUCCI: Object to form.

1 THE WITNESS: I'm not sure that  
2 that's the way it would be characterized.

3 BY MR. CHEFFO:

4 Q. Well --

5 A. -- I think we're --

6 Q. -- let's break it down.

7 A. -- at least at a -- at a -- at a net  
8 neutral --

9 Q. Okay.

10 So -- but --

11 A. -- situation.

12 Q. A net neutral.

13 So if you -- which means, under the  
14 statute, you can't make a profit.

15 So it's not a loss, right?

16 In other words, if you -- if you do  
17 them as an accommodation to the other counties,  
18 then you overall view that as getting back your  
19 costs and expenses.

20 But if you don't do them, you don't  
21 lose anything, right, because you're only  
22 charging for your costs and expenses under the  
23 statute, right?

24 MR. GALLUCCI: Object to form.

25 THE WITNESS: So if we are not doing

1 overdose autopsies for say Lake County, right,  
2 it doesn't cost us anything more not to do  
3 them.

4 But I'm not sure that it's an  
5 economic net gain.

6 BY MR. CHEFFO:

7 Q. Well, just --

8 A. It's certainly --

9 Q. Let's look at it --

10 A. It's certainly not a loss, right?

11 That's why I say it's kind of neutral.

12 Q. It's neutral, right, at -- at best,  
13 right?

14 I mean, in other words, if -- if --  
15 if I go and buy a sandwich and I pay \$3 that  
16 day, right, and it costs me \$3 for the  
17 sandwich; if I don't buy the sandwich the next  
18 day, I don't get the sandwich, and I don't lose  
19 the money, right?

20 Because, in other words, you --  
21 you've set a -- a cost that -- for these people  
22 that's supposed to be coordinate, right --

23 A. Uh-huh.

24 Q. -- with what it actually costs you  
25 to do it. So you're not losing any money if



1       you don't do it.

2           A.     Right.

3                   MR. GALLUCCI:   Object to form.

4                   BY MR. CHEFFO:

5           Q.     Right?

6           A.     I guess that's -- I just have -- a  
7       lot of it's embedded in the resources that  
8       we've already put into building the facility,  
9       having the equipment, things like that.   So,  
10      you know, it's more people's time.

11          Q.     Uh-huh.

12                  But -- but you --

13          A.     But I think that's a fair  
14      characterization.

15          Q.     Okay.   I mean you don't look at it  
16      as a -- as a profit center.

17          A.     No.   For sure.   That's not the case.

18          Q.     When you have done any of the  
19      analysis that you've talked about in connection  
20      with the 2015 to 2017, '18 data, has there been  
21      any input whatsoever by any lawyer?

22          A.     Any lawyer?   I mean I believe we  
23      had -- in early parts of the poison death  
24      review, we had someone from the prosecutor's  
25      office in the room.

1           Q.       Okay. Other than -- other than a --  
2       a -- a prosecutor, any outside lawyer? any  
3       lawyer for the county?

4           A.       No. Not to -- not to my knowledge.  
5       Not -- not in the analysis work that we've  
6       done.

7           Q.       Before any of the -- the reports --  
8       the -- the annual reports go up on the web  
9       site, are they reviewed by any law department  
10      that you know of?

11          A.       Not the law department, no.

12          Q.       Any lawyers?

13          A.       Not that I'm aware of.

14          Q.       In -- for let's say 2018, have you  
15      tried to break out what cause are specific --  
16      what costs are specifically associated with  
17      overdose deaths; or is that something that's  
18      part of your overall budget and operations?

19          A.       I believe we tried to embed that  
20      into the overall budget as best we could.  
21      Again, with 2018 having just finished, I  
22      haven't even seen the final analysis from OBM  
23      about how our budget ended up. So I -- I'm  
24      still waiting. That probably won't be done  
25      until the first quarter -- end of the first

1 quarter.

2 Q. So in any years -- in your seven  
3 years, have you ride to break out what specific  
4 costs above and beyond what your normal  
5 operations would be are attributable to  
6 overdose deaths?

7 A. Yes, we have.

8 Q. When did you do that?

9 A. I believe we've done a couple of  
10 memos. We did an initial one and then a couple  
11 of updates, budget presentation purposes. Any  
12 identified personnel, equipment that was  
13 needed, more testing supplies as best we could  
14 track it. There have been a couple at least.

15 Q. Why'd you do that?

16 A. Mainly because we had to justify any  
17 of the requests that we were putting through  
18 for additional funding. And resources are  
19 tight in county government already.

20 We certainly noticed that we had,  
21 you know, started to run low on supplies. We  
22 -- we had to order more often. Certain --  
23 certain things that are required in the  
24 forensic labs have shelf life. So you can't  
25 just buy in bulk and stock it on a shelf for a

1 whole year.

2 So we just kind of noticed that  
3 there were like more orders coming in. This  
4 was, you know, probably like 2015 when we  
5 started noticing those kind of things. It  
6 obviously got exacerbated in 2016 and '17.

7 Q. And -- and, if you can, just --  
8 maybe just macro, the bigger budgets of the  
9 whole office, right, what your approximate  
10 annual budget is, what percentage of it comes  
11 from the county, what from grants, and one from  
12 other contributions, for example, drug or DNA  
13 testing.

14 Just what are -- what are the  
15 buckets that ultimately go into your -- the  
16 buckets of sources that go into your -- your --  
17 your budget funding?

18 MR. GALLUCCI: Object to form.

19 THE WITNESS: So that's -- again,  
20 the bulk will be coming from the general fund.

21 BY MR. CHEFFO:

22 Q. What percentage?

23 A. Well, are we talking about this  
24 latest budget?

25 It's changed over the years, so

1 I'm -- just want to make sure I'm --

2 Q. Well --

3 A. -- getting it right.

4 Q. -- we can start wherever you --  
5 whatever's most top of mind.

6 A. So when -- 2011, when I came to the  
7 Medical Examiner's Office and Dr. Gilson  
8 arrived, I believe the budget for that year in  
9 aggregate was just under \$9 million.

10 This last budget, I believe we  
11 started somewhere around 12 and a half, maybe  
12 12.7. Again I don't have the final 2018 budget  
13 to know where we actually ended up.

14 So over that period of time, it's  
15 grown, you know, about -- by a third, which is  
16 significant. Some of that was planned because  
17 the forensic lab, as it exists today, didn't  
18 exist when we first got there. That is a  
19 project that we undertook, you know -- I think  
20 2013 is when we started in earnest.

21 And that also included adding new  
22 laboratories, new personal, new equipment,  
23 things like that. That accounts for some of  
24 the increase.

25 We certainly noticed that there was

1 more, you know, expenses coming out than --  
2 than we were tracking. And that's kind of why  
3 we tried to see if we could identify specifics  
4 in these memos regarding the opioid crisis.

5 I would say, if our budget is about  
6 12.7 this year, we'll have about 80 percent  
7 general fund. And then, as I said, the -- the  
8 grants that we get are not on our budget. So  
9 that would be in addition to our -- our written  
10 budget total, you know, the -- the 12.7 number,  
11 if that's what it is for '18.

12 Q. Was -- was it 80 percent in -- seven  
13 years ago?

14 In other words, has the contribution  
15 of the -- the county been relatively --

16 A. It may have been --

17 Q. -- steady?

18 A. -- a little bit higher. I would  
19 have to go back and -- and really check the  
20 numbers.

21 Q. So it's actually, you think,  
22 dropped?

23 A. Well, I think, as a percentage, on  
24 aggregate, general fund contribution has  
25 definitely increased. I think we've tried to

1 identify other sources as we can to deal with  
2 -- deal with the needs of the office.

3 As then --

4 Q. And as --

5 A. -- I've said --

6 Q. Sorry.

7 A. -- as -- as the crisis has kind of  
8 grown, we've gotten more requests from outside  
9 agencies. So while maybe we weren't charging  
10 absolutely cost, we doubled the number of cases  
11 that we were handling for other counties.

12 I think, when we first got there, it  
13 was under 200. Last year it was, you know,  
14 over 400. So those -- those -- the numbers  
15 everything goes into the -- what I call the  
16 medical examiner's lab. So that's --

17 Q. Right.

18 A. -- an increase in -- in overall  
19 revenue for that particular part of the budget.

20 Q. But the 400 you're being compensated  
21 for if you're -- if they're outside the county,  
22 right?

23 A. That's what I mean. That -- so  
24 that's additional -- right. It's an additional  
25 revenue source that we did not have seven years

1           ago.    Because it --

2           Q.     So it's a wash --

3           A.     -- it doubled.

4           Q.     -- right?

5                   The cost is -- whatever your budget  
6 needs are -- you get back because it's a  
7 revenue source under the statute, right?

8           A.     Understood.   But it still gets  
9 calculated in our --

10          Q.     Uh-huh.

11          A.     -- in our budget as additional  
12 revenue.

13          Q.     Okay.

14          A.     But we --

15          Q.     But also -- you mentioned that there  
16 was the creation of the -- the crime lab -- the  
17 forensic lab.   Excuse me.

18                   That didn't -- that wasn't an  
19 outgrowth of the opioid crisis, was it?

20          A.     No.   That was actually a planning  
21 process that predated Dr. Gilson and myself.  
22 There was actually nontax dollars set aside for  
23 construction and equipment.   But we had to pick  
24 up additional personnel.   And then obviously  
25 the supplies to run those new laboratories on a



1 day-to-day basis.

2 Q. And of the 12 and a half -- so there  
3 was an increase, you said, over the seven  
4 years, but some portion of it was attributable  
5 to the crime -- to the forensic lab, right?

6 A. Correct.

7 Q. How much of that?

8 A. I -- I would have to look at the  
9 specific numbers. It's --

10 Q. Roughly?

11 MR. GALLUCCI: Object to form.

12 BY MR. CHEFFO:

13 Q. Is it a million dollars a year?

14 MR. GALLUCCI: Object to form.

15 THE WITNESS: Perhaps. It's -- like  
16 I said, it -- it would help for me to see the  
17 budgets over the years.

18 BY MR. CHEFFO:

19 Q. What -- what would you look at?

20 A. Well, just to be able to have the  
21 numbers in front of me and what was attributed  
22 to say personnel, that we do have like specific  
23 line items for --

24 Q. Uh-huh.

25 A. -- equipment and contracts and

1 things like that.

2 Q. Yeah. That was a bad question.

3 I was just -- there's a -- there's  
4 an overall printout of a budget that you would  
5 look at, and you could then figure out how much  
6 was attributable to a various area --

7 A. In a --

8 Q. Right?

9 A. -- rough way, yes --

10 Q. Okay.

11 A. -- I can.

12 Q. Have you ever tried to figure out  
13 how much is associated with the cocaine  
14 epidemic?

15 MR. GALLUCCI: Object to form --

16 BY MR. CHEFFO:

17 Q. -- or crisis here?

18 MR. GALLUCCI: Object to form.

19 THE WITNESS: So the -- so the --  
20 the upswing in the number of cocaine-related  
21 deaths is tied almost directly to the upswing  
22 in fentanyl deaths. The cocaine supply has  
23 been largely adulterated with cocaine [sic].

24 BY MR. CHEFFO:

25 Q. But I'm talking about -- let's

1       assume -- I mean let -- that's in -- I think  
2       you testified in the last year or so, right?

3               But there's -- and I can show you a  
4       chart if you want. I'm sure you've seen it.

5               Cocaine has been historically a very  
6       significant driver of overdose deaths for the  
7       last ten years in Cuyahoga, right?

8               MR. GALLUCCI: Object to form.

9               THE WITNESS: It has been one of the  
10       more prevalent drugs, but it's been fairly  
11       steady.

12              BY MR. CHEFFO:

13              Q. I understand.

14              A. But it's -- it's --

15              Q. I -- I understand.

16              MR. GALLUCCI: Well, let's let him  
17       finish --

18              MR. CHEFFO: Yeah.

19              MR. GALLUCCI: -- his answer.

20              MR. CHEFFO: Okay.

21              BY MR. CHEFFO:

22              Q. I mean it's steady, but it's  
23       still -- you -- you --

24              MR. GALLUCCI: Okay. But you said,  
25       "Okay," and then you started talking.

1 Can he finish his answer?

2 MR. CHEFFO: Oh, I thought he did.

3 BY MR. CHEFFO:

4 Q. Did you finish?

5 A. That's fine. I -- I -- it -- it has  
6 been fairly steady over the last decade, yes.

7 Q. It's been steady, but it's been  
8 significant, in -- in fact, either the first or  
9 second most common drug of overdoses, right?

10 MR. GALLUCCI: Object to form.

11 THE WITNESS: It had been I think  
12 prior to 2013, yes.

13 BY MR. CHEFFO:

14 Q. Okay. And it's -- it's -- your --  
15 your recollection is it's remained steady,  
16 right?

17 A. So cocaine unadulterated with  
18 fentanyl has been fairly steady, yes.

19 Q. Have you tried to break out how much  
20 your office has expended on cocaine-related  
21 activities?

22 MR. GALLUCCI: Object to form.

23 THE WITNESS: Not as of yet, no.

24 BY MR. CHEFFO:

25 Q. Is there a plan to do it?

1 MR. GALLUCCI: Object to form.

2 THE WITNESS: Not currently that I'm  
3 aware of.

4 BY MR. CHEFFO:

5 Q. Has anyone ever done it?

6 MR. GALLUCCI: Object to form.

7 THE WITNESS: I don't know. Not in  
8 our office.

9 BY MR. CHEFFO:

10 Q. And you -- you've testified that  
11 there -- there was a rescinded spike in  
12 cocaine-related deaths. I think you said  
13 because there was a infusion or combination of  
14 the cocaine with fentanyl.

15 Is that your understanding?

16 A. Correct.

17 Q. And is that a situation where  
18 people, is it your understanding, intend to  
19 actually use cocaine laced with fentanyl; or is  
20 it something where the drug cartels or the drug  
21 dealers are using fentanyl to boost the -- the  
22 cocaine?

23 MR. GALLUCCI: Object to form.

24 THE WITNESS: I think there are a  
25 lot of possibilities in there. Some -- some

1 people seek fentanyl. Some people seek  
2 cocaine. Sometimes street drugs you can't be  
3 sure what you're getting. So there's a lot of  
4 possibilities, yes.

5 BY MR. CHEFFO:

6 Q. In -- in your work, though,  
7 you've -- you've heard that the law enforcement  
8 people -- this is a focus of theirs, right, in  
9 the last few years?

10 MR. GALLUCCI: Object to form.

11 THE WITNESS: What is their focus?

12 BY MR. CHEFFO:

13 Q. The -- the increase in cocaine laced  
14 with fentanyl?

15 A. Yes.

16 Q. And have you seen statements or  
17 reports that it's an effort by the drug cartels  
18 to actually lace the cocaine in order to target  
19 the African-American population?

20 A. Yes.

21 Q. That's something that's the position  
22 of the county, right?

23 MR. GALLUCCI: Object to form.

24 This is not a 30(b)(6) deposition.  
25 He can't speak as to position of the county.

1 BY MR. CHEFFO:

2 Q. Has the county taken a position, to  
3 the extent you're aware?

4 A. The --

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: The task force has --  
7 has definitely made that its position. I don't  
8 know that the county, in particular, has. I  
9 know that it's been stated by myself and Dr.  
10 Gilson in presentations that -- that that was a  
11 strategy, yes.

12 BY MR. CHEFFO:

13 Q. And you wouldn't state it unless you  
14 believed it, right?

15 A. I believe --

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: -- it, yes.

18 BY MR. CHEFFO:

19 Q. And the strategy is that the drug  
20 cartels unknowingly are putting a dangerous  
21 substance, fentanyl, into cocaine in order to  
22 essentially increase the potency and perhaps  
23 increase addiction amongst the people who are  
24 using the cocaine; is that right?

25 MR. GALLUCCI: Object to form.

1 THE WITNESS: It's -- it's hard for  
2 me to say what the cartels' intentions are.

3 What we've been told from a variety  
4 of sources, law enforcement among them, is that  
5 including fentanyl in cocaine was a strategy to  
6 get a new segment of the market that had kind  
7 of been steered away from opiates and heroin.

8 BY MR. CHEFFO:

9 Q. And I'm not trying to quibble with  
10 you, sir, but -- right.

11 By saying it's a strategy, isn't  
12 that the same thing as saying it was an  
13 intention or an effort by the cartels to hook  
14 people or increase the potency of cocaine?

15 MR. GALLUCCI: Object to form.

16 THE WITNESS: So again, not being a  
17 scientist, I'm not sure that characterizing  
18 adding fentanyl to cocaine as strengthening it.  
19 It's --

20 MR. CHEFFO: Okay.

21 THE WITNESS: These drugs work in  
22 kind of opposite ways. And that's --

23 MR. CHEFFO: Uh-huh.

24 THE WITNESS: -- why people who are  
25 expecting cocaine and get the mix die, or vice



1       versa, people who are seeking out fentanyl and  
2       get infusions of cocaine instead.

3               So I'm not -- I'm not sure that --

4               MR. CHEFFO:   Okay.

5               THE WITNESS:   -- that's a correct  
6       characterization.

7               The other --

8               BY MR. CHEFFO:

9               Q.     Let me --

10              A.     -- part of --

11              Q.     I'm sorry?

12              A.     -- your statement --

13              Q.     You go ahead.

14              A.     -- I would say that -- that's the  
15       intention there, the strategy.

16              Q.     Let me ask you a better question.

17                     What do you think the strategy is,  
18       as you understand it --

19              MR. GALLUCCI:   Object to form.

20              BY MR. CHEFFO:

21              Q.     -- of the cartels?

22              MR. GALLUCCI:   Object to form.

23              THE WITNESS:   To increase the  
24       current share of the market with people who are  
25       addicted to opiates and opioids.

1 BY MR. CHEFFO:

2 Q. But what is their strategy in -- in  
3 putting -- lacing cocaine with fentanyl?

4 MR. GALLUCCI: Object to form.

5 THE WITNESS: Well, if it doesn't  
6 kill the person, then they're now addicted to  
7 opioids instead, and they'll start seeking  
8 opiates and opioids out.

9 BY MR. CHEFFO:

10 Q. And have you said it -- said  
11 publicly or Dr. Gilson that, you know, a  
12 substantial portion of the people who are  
13 buying cocaine are not aware of the fentanyl?

14 MR. GALLUCCI: Object to form.

15 THE WITNESS: They may not be aware.

16 BY MR. CHEFFO:

17 Q. And if a -- and this is largely  
18 activity, you understand, from the drug  
19 cartels?

20 MR. GALLUCCI: Object to form.

21 THE WITNESS: That's what we've been  
22 informed, yes, by --

23 BY MR. CHEFFO:

24 Q. By --

25 A. -- partners.

1 Q. -- law enforcement, right?

2 A. Among others, yes.

3 Q. And these are drug cartels that are  
4 based outside the United States largely?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: I'm not sure based.  
7 I'm -- they have operations throughout the  
8 United States, so...

9 BY MR. CHEFFO:

10 Q. Well, where -- where is this cocaine  
11 laced with fentanyl coming from geographically?

12 A. That I don't know. I think, in  
13 general, a lot of it is coming from South and  
14 Central America. But where it -- where the  
15 fentanyl is actually introduced is a -- is a  
16 little bit unclear. At least from my end, I'm  
17 not as involved in the investigations from a  
18 law enforcement perspective.

19 Q. And if someone takes that and takes  
20 that -- strike that.

21 If someone uses that cocaine and  
22 they're not expecting it to be from fentanyl --  
23 or fentanyl in -- involved in it and has an  
24 overdose death, is the person who sold them  
25 that medicine responsible for their death?

1 MR. GALLUCCI: Object to form.

2 THE WITNESS: Responsible. Again,  
3 like I said, I'm sure everybody has a part to  
4 play in it.

5 BY MR. CHEFFO:

6 Q. And is the cartel that ultimately is  
7 developing this strategy, are they responsible?

8 MR. GALLUCCI: Object to form.

9 THE WITNESS: It's not no  
10 responsibility, no.

11 BY MR. CHEFFO:

12 Q. And -- and can --

13 A. But it's an outgrowth of, again,  
14 kind of the oversaturation of the market for  
15 opioids --

16 Q. So are the--

17 A. -- as a whole.

18 Q. So are the manufacturers and  
19 distributors of opioids, in the situation where  
20 someone laces cocaine with fentanyl, are they  
21 more responsible than the cartels and the drug  
22 dealers or less?

23 MR. GALLUCCI: Object to form.

24 THE WITNESS: Again, now we're  
25 getting back to how this crisis all kind of

1 unfolded.

2 BY MR. CHEFFO:

3 Q. Simple question.

4 MR. GALLUCCI: Go ahead and finish  
5 your answer.

6 THE WITNESS: It's a seemingly  
7 simple question. But unfortunately, this is a  
8 very complex situation.

9 Again, if the market had not been  
10 created, then maybe this never came to be.

11 BY MR. CHEFFO:

12 Q. Okay. But --

13 A. I -- I can't -- you're asking me to  
14 take a snapshot of what's happening now and  
15 assign some sort of responsibility, which is  
16 what this lawsuit's really going to determine,  
17 not -- not me, and what we believe that the  
18 root causes are, what I believe that's been  
19 informed by my work in the Medical Examiner's  
20 Office.

21 Q. And I'm not asking about the  
22 lawsuit. You keep bringing the lawsuit. I'm  
23 asking as your view. Okay?

24 In a -- in a situation -- I think  
25 you've told us you -- you -- you think that

1       there is a -- a number of factors, and there's  
2       a ultimate root cause that goes back many  
3       years, right?

4             A.       Yes.

5             Q.       And you've -- you've -- you've  
6       testified now that you can't quantify, but  
7       there's some responsibility to bear by the drug  
8       cartels and the drug dealers, right?

9             Yes?

10            A.       Yes.

11            Q.       And you believe others, including  
12       the defendants, have some responsibility,  
13       right?

14            A.       Yes.

15                    MR. GALLUCCI: Object to form.

16                    BY MR. CHEFFO:

17            Q.       And what I'm just trying to  
18       understand is, in the situation where a drug  
19       dealer sells a cocaine dose to an individual  
20       who doesn't know that he or she is getting  
21       fentanyl that was provided in connection with a  
22       cartel activity, is the drug dealer and the  
23       cartel -- are they more responsible or less  
24       responsible than let's say a pharmaceutical  
25       company or a pharmacy?

1 MR. GALLUCCI: Object to form.

2 THE WITNESS: So -- and you're still  
3 trying to get me to quantify this.

4 All I can tell you is -- is that,  
5 prior to this, we had, like I said, a steady  
6 number of cocaine-related deaths. None of them  
7 were cocaine and fentanyl until kind of the  
8 whole opiate crisis unfolded.

9 BY MR. CHEFFO:

10 Q. Really? Really. Okay.

11 Well, so then -- so then you would  
12 agree with me that nothing related to cocaine  
13 beforehand had anything to do with the  
14 defendants in this case, right?

15 MR. GALLUCCI: Object to form.

16 THE WITNESS: Well, I mean cocaine  
17 was created by a drug company century-plus ago.  
18 I don't know which one, but...

19 BY MR. CHEFFO:

20 Q. So they're responsible too?

21 Is that -- that's how you -- that's  
22 how far back the chain goes?

23 MR. GALLUCCI: Object to form.

24 THE WITNESS: Well, there were  
25 documented deaths after the civil war for

1 opiates. There were documented deaths at the  
2 turn of the 20th century for cocaine.

3 BY MR. CHEFFO:

4 Q. So --

5 A. So those were introduced as  
6 medicinal --

7 Q. Right.

8 A. -- drugs historically. So...

9 Q. So they're responsible in some way.

10 MR. GALLUCCI: Object to form.

11 THE WITNESS: Some way.

12 BY MR. CHEFFO:

13 Q. So some -- the -- whatever company a  
14 hundred or so years ago may have introduced  
15 cocaine, they're responsible for the drug  
16 dealer today who sells on behalf of a cartel in  
17 Cuyahoga County?

18 MR. GALLUCCI: Object to form.

19 BY MR. CHEFFO:

20 Q. In some way.

21 A. That -- in some way, that could be  
22 argued, yes.

23 Q. Right.

24 And the opioids, you know, have been  
25 around for hundreds, if not thousands of years,



1 right?

2 A. Correct.

3 Q. Derived from a poppy plant, I  
4 understand it, right?

5 A. Yes.

6 Q. So in some way, the people who first  
7 discovered the opioids are responsible for the  
8 opioid crisis here today, right?

9 MR. GALLUCCI: Object to form.

10 THE WITNESS: I'm not sure who  
11 you're referring to.

12 BY MR. CHEFFO:

13 Q. Whoever it was that determined that  
14 you can develop and get op -- an opioids out of  
15 a poppy plant, they have some responsibility  
16 for the opioid crisis, right?

17 MR. GALLUCCI: Object to form.

18 THE WITNESS: I --

19 BY MR. CHEFFO:

20 Q. Just like the cocaine inventor has  
21 responsibility.

22 MR. GALLUCCI: Object to form.

23 THE WITNESS: I mean I -- I think  
24 we're taking this back a little --

25 BY MR. CHEFFO:

1 Q. Really?

2 A. -- absurdly, but --

3 Q. Well, you'd say yes, right?

4 A. Yes.

5 MR. GALLUCCI: Object to form.

6 BY MR. CHEFFO:

7 Q. Even though it's absurd.

8 MR. GALLUCCI: Object to form.

9 THE WITNESS: No. The question was  
10 absurd, but --

11 BY MR. CHEFFO:

12 Q. But you just answered it "yes,"  
13 right?

14 MR. GALLUCCI: Object to form.

15 THE WITNESS: Yes.

16 BY MR. CHEFFO:

17 Q. I take it it can't be that absurd if  
18 you agree with it, right?

19 MR. GALLUCCI: Object to form.

20 BY MR. CHEFFO:

21 Q. Right?

22 A. I suppose.

23 MR. GALLUCCI: You want to take a  
24 break?

25 MR. CHEFFO: Let's just go another

1 minute or two.

2 MR. GALLUCCI: You want to -- well,  
3 we -- we ended up going way over the last  
4 break.

5 MR. CHEFFO: Okay.

6 MR. GALLUCCI: So now we've now gone  
7 through the lunch break.

8 MR. CHEFFO: Okay. If -- I mean  
9 I --

10 MR. GALLUCCI: So --

11 MR. CHEFFO: I usually get -- get  
12 one more question. But if you want a break  
13 right now --

14 MR. GALLUCCI: Let's --

15 MR. CHEFFO: -- we -- we can --

16 MR. GALLUCCI: Yeah. Take a break  
17 now. We've gone over an hour.

18 MR. CHEFFO: Okay.

19 THE VIDEOGRAPHER: We are going off  
20 the record.

21 This is the end of Media Unit No. 3.

22 The time is 12:54.

23 (A lunch recess was taken.)

24 (Deposition Exhibit 3 was marked for  
25 identification.)

1 THE VIDEOGRAPHER: We are back on  
2 the record.

3 This is the start of Media Unit No.  
4 4.

5 The time is 1:25.

6 You may proceed, Counsel.

7 MR. CHEFFO: Thank you.

8 BY MR. CHEFFO:

9 Q. Mr. Shannon, we've marked what is in  
10 front of you as Exhibit 3. You can just take a  
11 look at it.

12 It -- my understanding is that  
13 that's some kind of lengthy printout of budget  
14 line items?

15 MR. GALLUCCI: And, Mark, are there  
16 Bates numbers or anything related to it that we  
17 can identify it for the record?

18 MS. NEWMARK: Yeah. It's CUYAH,  
19 C-U-Y-A-H, underscore, 014627783.

20 MR. GALLUCCI: Okay. It's -- it's  
21 a -- it's a singular Bates number?

22 MR. CHEFFO: Yeah.

23 MR. GALLUCCI: Or is there a range?

24 MS. NEWMARK: It's one. It's --

25 MR. CHEFFO: Because I think it's

1       like a virtual --

2                   MS. NEWMARK:   It's --

3                   MR. CHEFFO:    It's a -- it's a  
4       printout from like an Excel spreadsheet.

5                   MS. NEWMARK:   We have it --

6                   MR. CHEFFO:    So there's no Bates on  
7       it.

8                   MR. GALLUCCI:   Okay.

9                   MS. NEWMARK:   Yeah.   It was native.

10                  MR. GALLUCCI:   That's fine.   And  
11       you've provided it to me on a --

12                  MR. CHEFFO:    Yeah.

13                  MR. GALLUCCI:   -- thumb drive as  
14       well.

15                  MS. NEWMARK:   Yeah.   The native  
16       version should be on the thumb drive.

17                  MR. CHEFFO:    Yeah.   I said virtual.  
18       It's native.   That's a better.

19                  BY MR. CHEFFO:

20                  Q.       But anyway, could you -- do you --  
21       I'm not going to ask you specific questions  
22       about it, sir.

23                  But can you just look at it and tell  
24       us if you know what that represents?

25                  A.       It's marked as "Total Expenditures."

1 If this is from the budget, it's in a format  
2 that I'm not used to seeing.

3 Q. Do you use Excel spreadsheets?

4 A. I do.

5 Q. And I'll just represent to you --  
6 I'm not testifying, but I -- I think that's a  
7 printout of an Excel spreadsheet.

8 Does that have the kind of  
9 information that you would expect to see on an  
10 expenditure printout?

11 A. As I said, if this is related to the  
12 budget, it's in a format I'm not familiar with.

13 Q. Okay. Is it -- what about the type  
14 of information that's listed in those tables  
15 that were produced to us by the county?

16 A. I mean I see figures in here. But a  
17 lot of this doesn't deal with my specific  
18 agency, so I --

19 Q. Okay.

20 A. Unless I was looking specifically at  
21 my agency numbers, I don't recognize anything.

22 Q. Do you believe your agency numbers  
23 are embedded within that larger document?

24 A. I -- I can look. I don't know how  
25 much time you want me to --

1 Q. Well, I -- I just- -

2 MR. GALLUCCI: Object to form.

3 I just want to note it's couple  
4 hundred pages.

5 MR. CHEFFO: Yeah.

6 MR. GALLUCCI: Right?

7 MR. CHEFFO: I think it's in  
8 alphabetical order. I -- I just --

9 MR. GALLUCCI: Okay.

10 MR. CHEFFO: I'm just asking him to  
11 look and find if he sees even any line items  
12 for the -- you know, for his department.

13 MR. GALLUCCI: Understood. If you'd  
14 like him to take the time and take a look,  
15 we're happy to.

16 MR. CHEFFO: Yeah. If -- sure. If  
17 he can tell.

18 THE WITNESS: That was fortuitous.

19 BY MR. CHEFFO:

20 Q. So I'm actually -- I -- I gave you  
21 my copy, sir. And I just -- I -- I just want  
22 to be clear for the record. It looks -- I can  
23 -- my eyes are not that good, but it looks like  
24 that's been highlighted. So I just want to be  
25 clear so it's not unfair.

1                   That may have been somebody on our  
2                   end highlighting that so we knew where to go.  
3                   I just want -- I don't want to represent to you  
4                   that that's what the original looks like.

5                   A.       Sure.

6                   MR. GALLUCCI: Counsel, if I may  
7                   ask, are -- you're referring -- are there  
8                   highlights within the red typeface, or is the  
9                   red typeface --

10                  MR. CHEFFO: I think the red  
11                  typeface is it. And I probably at -- at the  
12                  break would like to make sure that there's --  
13                  before we mark that, that there's nothing else  
14                  that's added or notes to me. But I -- I think  
15                  they highlighted it to make it clear as to  
16                  where the budgets were for the department.

17                  MR. GALLUCCI: Why don't we both  
18                  just take a look at the break and figure it  
19                  out.

20                  MR. CHEFFO: Okay.

21                  BY MR. CHEFFO:

22                  Q.       Do you see at least a few entries  
23                  that -- that relate to your department, sir?

24                  A.       It appears to be medical examiner  
25                  operations, regional forensic science lab,



1 medical examiner lab fund.

2 Q. And those are listed as  
3 expenditures.

4 Those are the costs that the  
5 department has to pay out for various things?

6 MR. GALLUCCI: Object to form.

7 THE WITNESS: That's what's listed  
8 here. It says "Total Expenditures 2005 to  
9 2017." And it's pages 73, 74 and 75 that have  
10 what's titled as our -- the Department of the  
11 Medical Examiner's Office.

12 BY MR. CHEFFO:

13 Q. Okay. And I'm not going to ask you  
14 any more questions about that. You can put  
15 that away if you'd like.

16 The -- we talked earlier about a  
17 budget. And I think you said that the budget  
18 for 2018 was approximately 12 and a half  
19 million dollars; is that right?

20 A. Give or take. I would have to go  
21 back and check to get specific numbers, yes.

22 Q. And I think you said you do a -- a  
23 biannual budgeting process that sometimes gets  
24 updated, depending on circumstances?

25 A. That's correct.

1 Q. And have you done '19 and '20?

2 A. I believe that the -- I believe  
3 biennium was '18, '19, if I'm not mistaken.

4 Q. So was the -- was the 12.7 budget --  
5 did you come -- did you exceed what was  
6 projected, or did you match it, or did you come  
7 in lower than the budget?

8 A. I would need the final report from  
9 the budget office, which I believe I stated  
10 earlier will come sometime towards the end of  
11 the first quarter of this year to see exactly  
12 where we came in with respect to the budget.

13 The last check of the budget at mid  
14 year, we were close -- pretty close to on  
15 budget. Some areas were a little under, but...

16 Q. So 12.7 was the 2018 budget; it's  
17 not necessarily how much you expended; is that  
18 right?

19 A. Right. The budget kind of sets the  
20 plan for the year of anticipated needs.

21 Q. And what's the budget for 2019?

22 A. I would have to go back and check.  
23 I'm -- it'll be in the same ballpark, I  
24 imagine.

25 Q. Where would you look for that?

1           A.       I would probably just check on past  
2 budget documents.

3           Q.       And that -- it would have been a  
4 budget that was submitted for 2018 and '19 to  
5 the county that they would have approved?

6           A.       Correct.

7           Q.       And your best understanding is the  
8 last time you looked about six months ago you  
9 were on target for the 12.7 budget for 2018?

10          A.       Yes.

11          Q.       Do you know if any requests or  
12 modifications were made for 2019?

13          A.       No. Not as of yet.

14          Q.       And in light of the significant  
15 reduction in overdose deaths in 2018, is it  
16 your expectation that you will need to revise  
17 or determine to revise down your budget since  
18 you had a significant drop in overdose deaths?

19               MR. GALLUCCI: Object to form.

20               THE WITNESS: I know we have not had  
21 that discussion yet. And it would be hard for  
22 me to determine that without seeing where we  
23 ended up from last year's budget.

24               BY MR. CHEFFO:

25          Q.       Right.

1 But it is somewhat basic math,  
2 right?

3 If things go up and you need more  
4 budget, you spend more; if they go down, you  
5 need less budget and spend less, right?

6 MR. GALLUCCI: Object to form.

7 THE WITNESS: That's a possibility,  
8 yes. But it's not necessarily -- budgeting's  
9 not, you know, a one-for-one. It's possible  
10 that there are residual effects and needs,  
11 embedded costs that we've already paid for and  
12 are paying for based on what we knew in 2017  
13 that were locked into a contract that will  
14 continue regardless of caseloads. So --

15 BY MR. CHEFFO:

16 Q. You just don't know?

17 A. I wouldn't -- I wouldn't want to  
18 speculate. I would prefer to have my -- my --  
19 my read of the final 2018 budget before I could  
20 speculate.

21 Q. But your -- your -- your best  
22 recollection is 2019 was in the 12 and a half  
23 million dollar range?

24 A. I -- I wouldn't --

25 MR. GALLUCCI: Object to form.

1 THE WITNESS: Yeah. Sorry.

2 I wouldn't think that it -- it would  
3 have been significantly different.

4 BY MR. CHEFFO:

5 Q. Is there a -- do you allocate a  
6 per-case cost or a per-autopsy cost to your  
7 cases?

8 MR. GALLUCCI: Object to form.

9 THE WITNESS: So the contracts that  
10 we have with the surrounding counties has a  
11 specific cost per case in the contract.

12 BY MR. CHEFFO:

13 Q. I'm talking about just you for  
14 budgeting purposes.

15 Is there some number that you --  
16 like let's say you were trying to figure out  
17 how much each cocaine autopsy -- or each  
18 autopsy of a person who overdosed on cocaine  
19 cost.

20 Is there a number that's been done?

21 A. Not to that degree of specificity.  
22 So it's not that a case for a car accident is  
23 more or less expensive than a case for a  
24 gunshot wound or -- it doesn't really work that  
25 way.

1           Q.     No. That's fair.

2                     But -- but let's assume then -- and  
3     that's -- thank you for that clarification.

4                     But assuming that you can't  
5     differentiate or don't differentiate between  
6     death investigations based on cause of death,  
7     right, or modality, is there some rough  
8     estimate that you apply from a budgeting  
9     perspective to each case?

10                    So if we have a case that we accept,  
11     and we do an autopsy, we've looked at it from a  
12     budget perspective, and we think that cause --  
13     costs X.

14                    Do you do something like that?

15            A.     So you said a couple of things in  
16     there. So when we do a death investigation,  
17     there are more pieces than just doing the  
18     autopsy.

19            Q.     Uh-huh.

20            A.     So there are other staff, other  
21     costs associated with that. To my knowledge,  
22     there hasn't been a complete review breaking it  
23     down the way that you're asking.

24            Q.     There has or hasn't?

25            A.     Has not.

1 Q. Has not.

2 A. What I do know is -- is that, when  
3 we -- Dr. Gilson and I arrived in 2011, they --  
4 Corner's Office at that time, then the Medical  
5 Examiner's Office, was charging X for other  
6 counties to do their autopsies on their behalf.  
7 That number has changed a couple of times since  
8 then.

9 But I -- I don't think I can get you  
10 like the kind of specificity that you're  
11 outlining.

12 Q. Okay. What -- so -- and that --  
13 that work for other counties, is that for full  
14 death investigations, or is -- is it only for  
15 autopsies?

16 A. So this gets back to kind of our  
17 discussion about jurisdiction. So we call them  
18 out-of-county cases, OU cases. This is a  
19 direct request from that county's --

20 Q. Uh-huh.

21 A. -- corner to perform an autopsy.

22 Q. Okay.

23 A. We are simply doing the work. The  
24 final decisions about how they're going to --  
25 how they're going to fill out the death

1 certificate is still under the jurisdiction of  
2 that county's corner.

3 Q. Fair.

4 And I think --

5 A. They'll take the information that we  
6 give them and make that final determination.

7 Q. Okay. Fair. Thanks for that -- for  
8 that clarification.

9 And I'm -- you -- you obviously can  
10 answer it any way you want. I'm just going to  
11 actually for a minute just be focusing on  
12 costs, right? So if we could just orient  
13 ourselves.

14 So out of county, what is done on  
15 other counties' behalf is just the autopsy, and  
16 there's a fixed cost for that, right?

17 A. Yes. There is a fixed cost in the  
18 contract for the autopsy work. And it includes  
19 kind of all our intake procedures. Any body  
20 that's coming into the building has to be  
21 documented so that we can track it and release  
22 it properly. Toxicology -- a basic toxicology  
23 panel will be done with the autopsy as well as  
24 any possible needs in the future for that  
25 forensic pathologist to testify on that



1 particular case.

2 We also provide them a list of  
3 forensic services in the laboratory that may be  
4 required. Say a -- a body that has not  
5 yesterday yet been identified, we may have to  
6 do a dental records comparison or a DNA test.

7 Those have fixed costs as well. The  
8 contract states that those will be discussed  
9 between our medical examiner and the corner  
10 who's referring to ensure that we are giving  
11 them what it is that they ask for and that they  
12 understand that there are additional costs  
13 associated with that.

14 Q. Okay. So it sounds like there's  
15 been some changes.

16 Just -- can you just tell us what  
17 the costs -- what the charges were, the basic  
18 costs, to an out-of-county municipality when  
19 you first joined and what any changes were  
20 along the way?

21 MR. GALLUCCI: Object to form.

22 THE WITNESS: I believe, when we  
23 first got in in 2011, they had been charging  
24 \$1,200 per case. Kind of did a review of what  
25 other -- there are other medical examiner and

1 corner's offices, usually in the larger  
2 metropolitan areas, that do the same thing.  
3 They're big enough. They've put the resource  
4 in to have the facilities and the staff to  
5 handle those kind of things.

6 We were certainly the lowest that we  
7 could find in Ohio. I believe we raised it to  
8 1,275 shortly after that review, understanding  
9 we still didn't feel that we were even getting  
10 close to covering the costs that were  
11 associated with a full autopsy.

12 There have also been legislative  
13 changes that required additional toxicology  
14 screens for specific drugs that we did not have  
15 set up in-house. So in order to do those  
16 panels, those specific tests, we would have to  
17 send it out, which is an additional cost. And  
18 then to develop the procedures necessary to  
19 handle those in-house also required resources  
20 and so forth.

21 So I -- I don't -- we were going  
22 to -- I think we were contemplating doing that  
23 last year. We did not. I think we are  
24 planning on implementing that later this year.

25 BY MR. CHEFFO:

1           Q.       And what we -- so it was 1,200 when  
2       you arrived; shortly after your review went to  
3       1,275; it's still been at 1,275 for the last  
4       seven years; and you're contemplating raising  
5       that, right?

6           A.       Correct.

7           Q.       And you're contemplating raising it  
8       because the 1,275 doesn't cover your costs.

9           A.       Correct. Especially with the added  
10       legislative mandates.

11          Q.       And what are you going to raise it  
12       to?

13          A.       I believe that we're currently  
14       looking at 1,475.

15          Q.       And 1,475 will be your -- you  
16       believe a fair representation of what your  
17       costs are without make -- taking a loss and  
18       without making a profit.

19          A.       I believe so. I think right now  
20       we're trying to investigate to make sure that  
21       we're not -- we're not exceeding what -- what  
22       those limits are.

23          Q.       It's -- but the current price is not  
24       adequate to meet your current costs, right?

25          A.       I -- I don't believe we -- we feel

1       that that's -- especially with the added  
2       legislative requirements, will cover our costs.

3           Q.       All right. So every -- every  
4       autopsy that you don't do for another county  
5       you, in effected, save money?

6                   MR. GALLUCCI: Object to form.

7                   THE WITNESS: I -- I'm still a  
8       little fuzzy on that characterization.

9                   BY MR. CHEFFO:

10          Q.       Really?

11          A.       It's a --

12          Q.       Okay. Let's -- let's try it this  
13       way: If -- if it actually cost you 1,475 to do  
14       something that you charge 1,275, don't you lose  
15       money on every autopsy that you do?

16          A.       I -- I suppose that, in a certain  
17       perspective, you could look at it that way.  
18       But as I said, when we first got here, we were  
19       doing less than 200 cases. Now we're doing  
20       more than 400 cases, so...

21          Q.       Right.

22                   So you're -- you're actually -- it's  
23       a good thing if you don't do those cases.  
24       Because you've just told us you can't even  
25       break even unless you raise your prices.

1           A.       Well, no. It's not a good thing.  
2       It's definitely bad practice not to. And we  
3       encourage, when we can, to have them send their  
4       cases to us.

5           Q.       Okay. And I -- and I apologize. I  
6       didn't mean to be flip about it. I was -- as I  
7       said, I'm just talking about economics right  
8       now.

9           A.       Right. No.

10          Q.       So I'm not talking about deaths  
11       or -- and I apologize if I was flip about --  
12       obviously the deaths are serious and important.

13                 I'm just talking about from an  
14       economic. Because one of the claims in the  
15       lawsuit is that there's -- there's some damages  
16       in claims, right?

17                 So that's what I'm trying to  
18       explore, right?

19                 So at the very least, if -- if you  
20       don't cover your costs at 1,275, putting aside  
21       other social issues and policy issues, you're  
22       not losing any money by not doing autopsies --

23                 MR. GALLUCCI: Object to form.

24                 BY MR. CHEFFO:

25          Q.       -- by doing something under what it

1 costs you.

2 MR. GALLUCCI: Same objection.

3 THE WITNESS: -- from a strictly  
4 fiscal standpoint, yes.

5 MR. CHEFFO: Okay. Let's mark this.

6 (Deposition Exhibit 4 was marked for  
7 identification.)

8 BY MR. CHEFFO:

9 Q. So, Doctor, these are one of these  
10 things that, you know, probably we could spend  
11 three days if you're -- you needed to read this  
12 cover to cover. And we're not. And I'm not  
13 going to ask you any really specific questions,  
14 I don't think.

15 But I wanted to see if I could  
16 understand what this is. And also I think you  
17 told us earlier that, if you had the report,  
18 you might be able to tell us what the ten-year  
19 kind of rate is of cases in your office.

20 A. I -- I might --

21 MR. GALLUCCI: Counsel -- sorry.

22 Counsel, before you question, I just  
23 note there's no Bates stamps on this.

24 MR. CHEFFO: Yeah. It's from the  
25 web site. So it's -- it's probably pulled from

1 the web site. I mean --

2 MR. GALLUCCI: Was it not produced  
3 also though in discovery?

4 MS. NEWMARK: No.

5 MR. GALLUCCI: I believe it was.

6 MS. NEWMARK: It was just posted.

7 MR. CHEFFO: So --

8 THE WITNESS: It was just posted.

9 MR. GALLUCCI: This is the most  
10 recently posted?

11 MR. CHEFFO: That's my  
12 understanding. Thank you for that. Yeah.

13 BY MR. CHEFFO:

14 Q. Is that right, Doctor?

15 A. So --

16 Q. Doctor. I'm sorry.

17 A. I'm not a doctor.

18 Q. Mister. Mister. I know you're not  
19 a doctor. I -- I'm so used to talking to your  
20 doctor colleagues.

21 A. Yes.

22 Q. Is that right, sir?

23 A. Yes. Yes. This was just posted at  
24 the beginning of January.

25 Q. Okay. And it's posted on the web

1 site, right?

2 A. Correct.

3 Q. And you've seen this before today?

4 A. I have.

5 Q. Did you take part in the preparation  
6 of this document?

7 A. To some extent, yes.

8 Q. And what is it? What is it?

9 A. This is our statistical report for  
10 the work done in 2017 in the Medical Examiner's  
11 Office.

12 Q. So when you said you were doing  
13 additional work on 2015, '16, 17, is that  
14 something different than the statistical report  
15 of the Medical Examiner's Office?

16 A. Yes.

17 Q. And -- and how would you  
18 differentiate those -- those two bodies of  
19 work?

20 A. So this is -- this is a strict I  
21 think telling of numbers. It doesn't in --  
22 involve analysis. So it's a numerical  
23 representation of the work that was done by the  
24 office.

25 THE REPORTER: Can we go off the



1 record.

2 MR. CHEFFO: Off the record? Sure.

3 THE VIDEOGRAPHER: We are going off  
4 the record.

5 The time is 1:46.

6 (A short recess was taken.)

7 THE VIDEOGRAPHER: We are going back  
8 on the record.

9 The time is 1:50.

10 You may proceed, Counsel.

11 BY MR. CHEFFO:

12 Q. So I think I had asked you, sir,  
13 what -- what your general role was in the  
14 preparation of this document.

15 A. Should we -- the general layout, it  
16 changes year to year. Some of the specific  
17 information that gets put in I collect from the  
18 various department heads and give it to the  
19 designers.

20 And we actually have an internal  
21 team that does most of the heavy lifting. But  
22 I do play intermittent roles. I do review  
23 sections before they get proofread, those kinds  
24 of things.

25 Q. Okay. And what's the -- what's the

1        purpose of the -- of preparing and distinct  
2        this document to the public?

3            A.        Well, there's historical purpose.  
4        The Cuyahoga County coroner's office has  
5        produced a document like this since like 1937  
6        continuously. There was a brief interruption  
7        right before we got in, but we did that kind of  
8        in -- after the fact.

9            It is a requirement of our  
10        accreditation with the National Association of  
11        Medical Examiners to be able to produce a  
12        report that will illustrate the work of the  
13        office.

14            As I said, it's basically a  
15        numerical representation of the work that the  
16        office did the previous year.

17            Q.        And are -- is the office -- the  
18        department accredited currently?

19            A.        Yes.

20            Q.        By which organization?

21            A.        So the National Association of  
22        Medical Examiners accredits the medical  
23        examiner portion. I believe we're in  
24        provisional accreditation at the moment due to  
25        heavy caseloads because of the opioid crisis.

1       That will be resolved I believe in April. Each  
2       of the individual forensic laboratories, as  
3       well as the forensic laboratory overall, also  
4       have individual accreditations through their  
5       various accrediting bodies.

6               ABFT, the American Board of  
7       Toxicology, accredits the toxicology  
8       department.

9               ASCLD is the Association of Crime  
10      Lab Directors. They do the overall forensic  
11      lab accreditation.

12              The DNA lab has to conform to  
13      specific standards of the FBI to be able to  
14      upload into CODIS, which is the national DNA  
15      database.

16              AABB is the American Association of  
17      Blood Banks. They also have a role in  
18      accrediting portions of the DNA lab as well as  
19      our parentage and identification laboratory.

20              The ACGME, Council of Graduate  
21      Medical Education accredits, the teaching part  
22      of the office. And we have the longest running  
23      forensic training program in the United States.  
24      We usually have one or two fellows who become  
25      forensic pathologists once they've completed

1       their training. It's a yearlong fellowship.

2           Q.       Okay. And other than the  
3       provisional certification that you have right  
4       now, have you -- well, strike that.

5                    With -- when did the professional  
6       certification go into effect?

7           A.       I believe in 2017.

8           Q.       What month; do you know?

9           A.       I believe we're a April inception.  
10       So it would have been April. Or at least that  
11       would have been when the inspection was done.  
12       They probably didn't let us know until June or  
13       July, sometime over the summer.

14          Q.       And is it your understanding the  
15       only basis for the provisional certification is  
16       the number of cases you've handling?

17          A.       So because of the caseloads --  
18       there's a list of requirements. And if you  
19       don't meet them, you get either a class one or  
20       class 2 or A or B. I -- I can't remember.  
21       Kind of a demerit. And you can only carry so  
22       many to be an accredited facility.

23                    Unfortunately, the caseloads are all  
24       tied in to a number of the provisions.  
25       Toxicology caseloads were high. The turnaround

1 times didn't meet the standards. That  
2 predicates the turnaround times for the overall  
3 autopsy completion. So it was kind of a double  
4 hit.

5 And then the actual caseloads by the  
6 doctors themselves, they're supposed to stay  
7 under 250 for a -- kind of a minor demerit and  
8 under 300 for the major. And we had several  
9 doctors at the were over 300, after the 2016  
10 caseload. A year.

11 And then.

12 Q. Other than --

13 A. Yeah.

14 Q. Other than the -- the caseload, is  
15 there any other factors that you're aware of  
16 that went into the provisional certification,  
17 or were they all related in some way, in your  
18 view, to the caseload issue?

19 A. Well, the other thing was is that  
20 this report actually was late in being  
21 produced. It was not ready when the inspection  
22 took place.

23 Again, we had been somewhat  
24 overwhelmed in 2016. We also lost staff who  
25 had previously been doing this. And so we were

1 scrambling to try to find somebody who could.  
2 So I think that was the final piece that --  
3 that --

4 Q. Okay.

5 A. -- didn't exist.

6 Q. How many more -- how many more cases  
7 did you have in 2016 and 2017 that overwhelmed  
8 every aspect of your department?

9 A. It was a significant percentage. I  
10 would have to look to get you the --

11 Q. Okay. We --

12 A. -- actual numbers, but --

13 Q. I'll ask you to.

14 But you -- you -- you don't recall?

15 A. Like I said, we doubled the number  
16 of drug deaths. So that was a significant  
17 portion right there.

18 Q. What were the -- what were the  
19 percentage of drug deaths in your overall  
20 caseload?

21 A. In 2016 or prior -- prior to that  
22 or --

23 Q. Roughly 2016, 2017.

24 A. Well, I mean it changed  
25 significantly in 2016 because we doubled the

1 number of drug deaths. So --

2 Q. Okay.

3 A. It went from about 350 to almost 700  
4 in a year.

5 Q. Okay. So when it was -- when it was  
6 350, what was that percentage of your overall  
7 caseload?

8 A. Perhaps -- it was less than 10  
9 percent.

10 Q. Less than 10 percent.

11 And when it went -- when it doubled  
12 -- or -- I'm sorry.

13 Did you say doubled?

14 A. Yes.

15 Q. When it doubled, what was the  
16 overall percentage?

17 A. It would have been closer to 20  
18 percent, but...

19 Q. So that 10 percent jump is -- is it  
20 your testimony that that completely overwhelmed  
21 all aspects of your -- your department or only  
22 certain places?

23 A. So it -- again, this is kind of an  
24 involving process. There are other factors  
25 that weighed in. We lost doctors and staff.

1 Forensic pathologists don't grow on trees.  
2 They're hard to replace.

3 And so I believe -- also at the time  
4 we had -- the fellows that I mentioned earlier  
5 are working on cases. And we had two fellows  
6 at -- at -- at the time. We lost one in the  
7 next round.

8 So again, the accreditations were  
9 tied to doctor caseloads. That has a  
10 significance impact when you double the number  
11 of drug cases and lose two doctors. So we were  
12 kind of trying to backfill to get staffing back  
13 to appropriate levels.

14 Q. And you didn't lose the doctors  
15 based on the overdose increases, did you?

16 A. No. I think one relocated with her  
17 husband to another jurisdiction. And again,  
18 the fellows are working fellows. And they only  
19 have a year term. And we only had one fellow  
20 for the subsequent term. So, in essence, we  
21 lost a doctor.

22 Q. So even if there was not an increase  
23 in the overdose deaths, you would have had some  
24 challenges, having lost a doctor, lost a  
25 fellow, right?



1           A.       It would have been a challenge. I'm  
2       not sure that it would have been to the -- to  
3       the point where it pushed our accreditation  
4       limits.

5           Q.       But let's talk about preparing this  
6       report.

7                    The -- the people who prepare this  
8       report, those aren't the same people who are  
9       doing the autopsies, are they?

10          A.       No.

11          Q.       And they're not the investigators  
12       who are investigating overdose deaths, are  
13       they?

14          A.       No.

15          Q.       So you told me you were so  
16       overwhelmed that -- by the overdose deaths that  
17       this couldn't get published. I'm just trying  
18       to understand how.

19                    Like what -- what did the -- the  
20       10 percent increase in your overall caseload do  
21       such that a -- a report done by nonmedical  
22       professionals and noninvestigators couldn't be  
23       done?

24          A.       So I believe I mentioned that the  
25       person who had been responsible for the

1 majority of this report had retired. And we  
2 were looking for someone who could replace that  
3 person --

4 Q. Okay.

5 A. -- with the requisite skills to --  
6 to do it properly.

7 Q. So that was a -- unfortunate, right,  
8 and -- and probably challenging.

9 But that was a personnel issue based  
10 on retirement, right?

11 A. Yes.

12 Q. Nothing to do with the overdose  
13 increases, right?

14 A. Not this specifically, no.

15 Q. So -- so in -- and again, feel free  
16 to look at this if you need to. That's why I  
17 put it in front of you. But I -- I -- I'm just  
18 going to ask you a few questions about kind of  
19 rates.

20 It -- what -- prior to 2016, were  
21 the cases -- the overall cases, were they  
22 relatively linear that your office held?

23 And if you'd be kind enough to tell  
24 us where you're looking. Unfortunately there's  
25 no pages on this.

1 Oh, is there? Oh, I apologize.  
2 There is pages on the left. Actually, on the  
3 left, on the right, depending on which page  
4 you're looking at.

5 Is it 44 that we're up to?

6 A. I forget how big this book is.

7 So Page 44, that is data taken from  
8 the Ohio Department of Health on the overall  
9 deaths in Cuyahoga County.

10 Q. Okay.

11 A. And as I stated before, not  
12 everybody who dies even gets referred to the  
13 Medical Examiner's Office.

14 Page 45 --

15 Q. Can we stay on 44 for a minute.

16 So just -- even with -- the height  
17 of the deaths in the county, we're in like  
18 2012, '13, '14, right?

19 And then they dropped in '15, '16,  
20 '17?

21 Am I reading that right?

22 A. That's what it says, yes.

23 Q. Okay. And then 45 is what?

24 A. 45 will be -- it says a ten-year  
25 period of cases that are referred to the

1 Medical Examiner's Office. So you can see  
2 there have been basically a steady increase  
3 2012, '13, '14, '15, and then it jumps in '16,  
4 and then up slightly in '17.

5 Q. Well, let's just --

6 A. And --

7 Q. -- talk --

8 A. But --

9 Q. Let's take it one at a time.

10 So I mean you say steady increase,  
11 but there's -- '12 to '13 is what, like 20 or  
12 30 case, right?

13 A. 30, yeah.

14 Q. That's in the -- in the context of  
15 2,258.

16 That's pretty similar, isn't it,  
17 from a year over year from a percentage basis?

18 A. And the same with '14 and  
19 actually --

20 Q. But from a kind of a statistical  
21 look, you'd say flat, right?

22 A. Right.

23 Q. And then '15 there was an increase.  
24 And again, I -- I won't apologize. And I -- I  
25 -- other than to just make clear to you. I

1 know these represent deaths. So they're all  
2 very serious.

3 A. Right.

4 Q. I have to ask you statistical  
5 questions about them. It's not because I'm  
6 trying to minimize the issue of deaths. I'm  
7 just trying to -- right now we're talking about  
8 damages in the case and statistical issues. So  
9 I'm going to be somewhat formulaic about it.  
10 But, you know, I understand we're talking about  
11 real people.

12 Fair?

13 A. Understood.

14 Q. So it's -- the -- the death -- the  
15 number of cases that your -- your department  
16 handled from 2012 to '14 is flat. Then there  
17 is an increase in 2015.

18 But would you agree with me, from a  
19 percentage basis, it's --

20 A. About 10 percent.

21 Q. From '14 to '15?

22 A. Right. In the 200 cases.

23 Q. Okay.

24 A. Out of 22 -- so under 10 percent.

25 Q. And then did that 10 percent

1           overwhelm the department?

2           A.       No.    But we started noticing the  
3           strains --

4           Q.       Right?

5           A.       -- in 2015.

6           Q.       And you had at that point more  
7           interns, more fellow and a doctor who hadn't --  
8           decided for family reasons to move somewhere  
9           else, right?

10          A.       Correct.

11          Q.       And then in 2016 there's another  
12          jump of approximately what percent?

13          A.       That would be -- 450 cases out of  
14          245.    So 17, 18 percent.

15          Q.       Okay.   And just the number in -- the  
16          extra 175 cases didn't overwhelm the  
17          department, right?

18                    There were other factors, including  
19          retirements and -- and other issues, right?

20          A.       Between '15 and '16?   It's a 450 --

21          Q.       Well, I -- that's what I had asked  
22          you, what the percentage was.

23          A.       About 17, 18 percent.

24          Q.       That's 17 percent.

25          A.       Yeah.   That started to strain the

1 resources of office, yes.

2 Q. The number as well as the other  
3 factors we talked about?

4 A. Yes.

5 Q. And then in 2017 it looks like there  
6 was an increase but proportionately probably  
7 statistically flat, right, about 50 more cases?

8 A. Right. 50 out of 2,900, yeah.

9 Q. And then what does the 2018 number  
10 look like?

11 A. Again, we're compiling those  
12 statistics now. So --

13 Q. Yeah. But --

14 A. I would say, in general, they've  
15 gone back down some.

16 Q. Have they gone back down to the 2015  
17 levels?

18 A. No. Probably not. Probably not  
19 that far down, no.

20 Q. Can you give me a -- a rough?  
21 Is it about 20 percent?

22 MR. GALLUCCI: Object to form.

23 THE WITNESS: Not 20 percent, no.

24 Again, I -- it'd be helpful, once we  
25 have the final numbers, to be able to be more

1       precise. I know it's gone down. I don't  
2       believe it's gone down to the levels where 2015  
3       is at.

4               MR. CHEFFO: Okay.

5               THE WITNESS: And again, you also  
6       have to take into account this is just the work  
7       that's done within the jurisdiction, the IN  
8       cases. This doesn't take into account the  
9       increases that we had in the out-of-county  
10      cases.

11             Q.       Okay. And the -- and all these  
12      numbers are not obviously just drug overdoses,  
13      right?

14                    This include all manner of cases,  
15      right?

16                    Children cases you told us about and  
17      homicides and everything else, right?

18             A.       Correct.

19             Q.       And in addition to -- just from an  
20      -- other than the drug overdose cases that  
21      increased in 2016, were there -- were there  
22      other drivers to increase the number?

23             A.       I would have to go back and look. I  
24      believe we've been seeing steady increases in  
25      suicides, gun-related deaths, homicides.



1       They've all had some increases. Not to the  
2       statistical swings that we were seeing in the  
3       drug cases but certainly contributing to the  
4       increased caseloads.

5           Q.     And are -- if someone takes their  
6       life via overdose using some type of drug or  
7       chemical, legal or illegal, is that listed and  
8       counted as a statistic for a overdose death?

9           A.     It is.

10          Q.     Is that consistent with how your  
11       neighboring jurisdictions treat suicides?

12               MR. GALLUCCI: Object to form.

13               THE WITNESS: I would have to check  
14       each individual one. Some of them do; some of  
15       them don't.

16               BY MR. CHEFFO:

17          Q.     Do you know anybody else, any other  
18       county, that includes suicides in drug overdose  
19       deaths?

20          A.     Again, I would have to check with  
21       them specifically to see how they keep their  
22       statistics.

23          Q.     And that's all I'm asking you, sir.

24               I mean do -- do you know one way or  
25       the other?

1           A.       Not -- not off the open of my head,  
2       no.

3           Q.       Are you -- can you name even one  
4       other ME's office that includes suicides as  
5       part of drug overdose deaths?

6           A.       Again, I don't have any one specific  
7       that I know of. Technically there's only one  
8       other Medical Examiner's Office in the State of  
9       Ohio. That's Summit County. The rest of them  
10      are corner's offices. But I don't know that  
11      any of them -- whether they do or don't.

12          Q.       Fair.

13                 I mean I'll -- I'll broaden it.  
14       Because you're -- you're appropriately being  
15       more specific. And I -- I appreciate that.

16                 In the entire country, including  
17       corners or medical examiner's offices, are  
18       you -- can you identify any of them that  
19       include suicides in the overdose death  
20       statistics?

21                 MR. GALLUCCI: Object to form.

22                 THE WITNESS: Again, I can't  
23       specifically say one way or the other, no.

24                 BY MR. CHEFFO:

25          Q.       Can you see how that could be a

1       little misleading?

2               MR. GALLUCCI: Object to form.

3               THE WITNESS: You'll have to be more  
4       specific.

5               BY MR. CHEFFO:

6               Q.       Well, an overdose death rate, one of  
7       the things that you use in your task force,  
8       right, is to look at statistics so you could  
9       try to interdict and figure out where to put  
10      resources, how to treat people, right, how to  
11      stem the tide of people who are inadvertently  
12      trying -- using and abusing medicines and  
13      perhaps inadvertently dying, right?

14              A.       They're overdosing by taking drugs,  
15      yes.

16              Q.       By accident, right?

17              A.       That's how they're -- that's how  
18      they're termed, yes.

19              Q.       It's a different analysis and  
20      different public health issue, isn't it, for  
21      people who are intentionally taking substances  
22      to kill themselves?

23              MR. GALLUCCI: Object to form.

24              THE WITNESS: It can be. A lot of  
25      the drug users are dual diagnosed with mental

1 health issues, somewhere in the 40 to 50  
2 percent range. So there's a lot of overlap,  
3 meaning the -- there's a lot of overlap between  
4 people who have substance abuse disorder and  
5 mental health issues.

6 They're sometimes very similar.  
7 Again, that's why the ADAMHS Board, the  
8 Alcohol, Drug and Mental Health Services Board,  
9 they work on all of those issues. They call  
10 them, you know, deaths of despair. Suicide and  
11 drug overdoses are very similar in -- in a lot  
12 of cases.

13 And so they -- they are -- and --  
14 and this was a discussion at the task force,  
15 that they do need to be addressed in tandem  
16 with each other.

17 BY MR. CHEFFO:

18 Q. And you would agree with me that  
19 actual suicides in the overdose population are  
20 actually underreported because it's often hard  
21 to really differentiate without concrete  
22 evidence that someone intended to take their  
23 life, right?

24 MR. GALLUCCI: Object to form.

25 THE WITNESS: Well, that can be the

1 case in any suicide.

2 I will say that the majority of  
3 suicides are done by gun or hanging. So the  
4 ones that involve substance abuse, specifically  
5 ones that involve opioids, are relatively rare.

6 BY MR. CHEFFO:

7 Q. Do you -- the ones that are done by  
8 guns or hanging, are those include -- are those  
9 characterized as accidents?

10 A. No. They're characterized as  
11 suicides when it's indicated.

12 Q. They're not -- the ones by gun are  
13 not characterized as homicides, right?

14 If someone takes --

15 MR. GALLUCCI: Object --

16 BY MR. CHEFFO:

17 Q. -- their own life with a gun?

18 MR. GALLUCCI: Object to form.

19 THE WITNESS: So that's more of a  
20 forensic pathologist question about how they  
21 make the determination. There are cases where  
22 it's not clear.

23 BY MR. CHEFFO:

24 Q. And I -- I'm only talking just --  
25 when it is clear, right?

1                   So in other words, if it's  
2                   determined that the -- the -- the cause of  
3                   death after full investigation is death by  
4                   intentional gunshot wound by the individual,  
5                   that's labeled as a suicide, right?

6                   A.       Correct.

7                   Q.       It's not also then labeled as a  
8                   homicide, is it?

9                   A.       No.

10                  Q.       And when someone hangs themselves or  
11                  takes their life in some other way, it's not  
12                  characterized as a accident, is it?

13                  A.       Not if there's evidence to prove  
14                  that- - or to show that it was intentional, no.

15                  Q.       But when it's a suicide with  
16                  overdose, it's characterized as an overdose.

17                  A.       No. So that's a modality, and  
18                  that's not a manner. So when somebody takes  
19                  drugs to kill themselves and there's evidence  
20                  present, it's ruled as a suicide. The modality  
21                  is drug overdose, but that's not...

22                  Q.       Okay. Fair enough.

23                         So it's counted -- if they -- if  
24                         they take their own life using drugs, it's  
25                         declared -- determined to be a suicide, but

1       it's counted in the overdose statistics for  
2       your county.

3           A.       Right. Because that's modality of  
4       death.

5           Q.       And when someone commits suicide by  
6       gunshot wound, is it captured in any statistic  
7       other than suicide?

8           A.       Yes.

9           Q.       What else would it be?

10          A.       Homicide, accident, undetermined.

11          Q.       Always?

12          A.       No, not always. It depends case by  
13       case. So again, gunshot wound is the modality.  
14       They died by a gunshot wound. Just like an  
15       overdose dies of a drug overdose.

16                 Gunshot deaths are tracked as a  
17       modality. Some of them are homicide; some of  
18       them are suicide; some are accidents.

19          Q.       I think we're -- just by my bad  
20       question, we may be talking past each other.

21                 But I understand that gunshot wounds  
22       can be a whole host of things, right?  
23       Accident, homicide, suicide, maybe others.

24                 But if it goes through the system,  
25       and some smart person determines that it's

1       actually, unfortunately, a suicide, right, for  
2       statistical purposes is it also listed as a  
3       homicide?

4           A.       No.

5           Q.       And an intentional hanging is not  
6       listed also as a accident; it's listed only as  
7       a suicide, right?

8           A.       Correct.

9                   MR. GALLUCCI: Object to form.

10                  BY MR. CHEFFO:

11          Q.       For statistical purposes.

12                  MR. GALLUCCI: Object to form.

13                  THE WITNESS: For the manner of  
14       death, yes. Not the modality.

15                  BY MR. CHEFFO:

16          Q.       And do you know what the percentage  
17       of suicides are that are included in the  
18       overdose death statistics?

19          A.       As I said, it's not a large number.  
20       I would need to get access to our data to be  
21       able to give you a specific answer.

22          Q.       And even there it's -- would you  
23       agree with me, because of the overlap between  
24       mental illness and individuals who abuse drugs,  
25       it's not always a clear determination?



1           A.       That's not my area of expertise.

2       That's a forensic pathologist question.

3                   MR. GALLUCCI:   Object to form.

4                   BY MR. CHEFFO:

5           Q.       Okay.   I mean you -- you --  
6       you've -- you've testified a bit of today that  
7       you have some level of knowledge about people  
8       who abuse and your views about psychological  
9       disorder versus physical dependence.

10                   So do you believe that people who --  
11       and I think you just testified two minutes ago  
12       that there's an overlap between areas of mental  
13       health and drug abuse, right?

14           A.       There is a overlap in people who  
15       suffer from both, yes.

16           Q.       Okay.   And do you -- do you know  
17       then whether there is -- have you seen anything  
18       or talked in -- in the forensic community that  
19       suicides are underreported?

20                   MR. GALLUCCI:   Object to form.

21                   THE WITNESS:   I don't recall  
22       specific case where we've discussed that  
23       suicides are underreported, no.

24                   BY MR. CHEFFO:

25           Q.       Is it your understanding that, in

1 order -- and probably a host of reason, right?  
2 Potential family issues and -- and other social  
3 issues that, unless there's very clear  
4 evidence, suicide is not determined to be a  
5 cause of death?

6 A. Can you -- can you repeat that? Or  
7 can you give it to me...

8 Q. Sure.

9 I don't want to mischaracterize Dr.  
10 Kohler's testimony, but I'll give you my best  
11 recollection.

12 A. Okay.

13 Q. It was something along the lines of,  
14 unless we're very sure, we see a note, we have  
15 clear evidence of suicide, we don't declare  
16 something suicide because of potentially  
17 various other -- family and other factors, and  
18 it's a policy. So kind of, if in doubt, and we  
19 think someone overdosed, it's declared an  
20 overdose.

21 MR. GALLUCCI: Object --

22 BY MR. CHEFFO:

23 Q. My question is are you aware of any  
24 kind of formal or informal policy or practice  
25 whereby overdose deaths or other -- other

1 deaths are not deemed to be a suicide by the  
2 department unless there is a -- a -- a higher  
3 level of -- of proof or showing than might be  
4 the case in some other causes of death?

5 MR. GALLUCCI: Object to form.

6 THE WITNESS: Yeah. That's you  
7 citing Dr. Kohler. She's a medical examiner.  
8 That's really a forensic pathologist question.

9 BY MR. CHEFFO:

10 Q. Fair. You don't know.

11 A. Yeah.

12 MR. CHEFFO: Okay. Can -- let's  
13 mark this document, please.

14 If we can just mark this document,  
15 please.

16 (Deposition Exhibit 5 was marked for  
17 identification.)

18 BY MR. CHEFFO:

19 Q. Would you take a look, sir, at  
20 Exhibit 5.

21 You've seen this before, right?

22 A. I have.

23 Q. On the front page I think there's  
24 just a typo. It's -- should be January 11th,  
25 2019.

1           A.       Yeah.

2                   MR. GALLUCCI:   Also, just for  
3       clarification, the first page after the cover,  
4       or are you on the cover?

5                   MR. CHEFFO:    I'm sorry.   On the  
6       cover.   Thanks, Frank.

7                   MR. GALLUCCI:   Okay.

8                   MR. CHEFFO:    Yeah.   Yeah.

9                   There's -- there's no -- I -- let me  
10      make sure I'm correct about this.   There's no  
11      numbers or Bates stamps on this.   I think this  
12      is...

13                  BY MR. CHEFFO:

14                Q.       But this is a recent document from  
15      just a few weeks ago, right?

16                A.       Correct.

17                Q.       And -- and was -- was this published  
18      on the web site; do you know?

19                A.       Yes.

20                Q.       Did you play a role in -- in  
21      assembling this or reviewing it?

22                A.       Yes.

23                Q.       And what was your role?

24                A.       Taking the data that -- that we  
25      collect as we go and putting it into this

1 report.

2 Q. Do you work with somebody else who  
3 assists you in preparing this?

4 A. Some of the information comes from  
5 other agencies. So we do work with other  
6 people. But in -- in the actual compilation, I  
7 -- I do most of this myself.

8 Q. Okay. So pretty much this -- you  
9 know, this is generated by you at your computer  
10 compiling information?

11 MR. GALLUCCI: Did you have  
12 something --

13 THE WITNESS: Yes.

14 MR. GALLUCCI: -- you were still  
15 adding?

16 THE WITNESS: Yeah. I just wanted  
17 to point out that this one's marked. I didn't  
18 know if that was appropriate --

19 MR. CHEFFO: Oh.

20 THE WITNESS: -- for the --

21 MR. CHEFFO: Yeah. Thank you for  
22 that.

23 THE WITNESS: -- exhibit.

24 MR. CHEFFO: I -- I think -- let me  
25 just -- can I have another copy?

1 MR. GALLUCCI: Yeah. Thank you  
2 for...

3 MR. CHEFFO: Yeah. Thanks, sir.  
4 We'll -- we'll -- let's make a note.  
5 We'll just change it.

6 MR. GALLUCCI: We'll switch his  
7 copies out.

8 (Discussion held off the  
9 stenographic record.)

10 THE WITNESS: I don't know if it  
11 makes a difference or...

12 MR. CHEFFO: No, no, no, no. You --  
13 you did the right thing. It's -- it doesn't  
14 make a difference, but it's better to have an  
15 adulterated document.

16 MR. GALLUCCI: Keeps me from  
17 complaining later.

18 MR. CHEFFO: Yeah, yeah.

19 MR. GALLUCCI: And so we've  
20 renumbered it. There was a 5 on it. We've  
21 changed the date to 2019. Otherwise, there's  
22 no markings that have been --

23 MR. CHEFFO: Okay.

24 BY MR. CHEFFO:

25 Q. So back to this medical examiner's

1 heroin, fentanyl, cocaine related deaths in  
2 Cuyahoga County.

3 This is -- what -- what was the  
4 purpose of this document?

5 A. It was to provide the community a  
6 baseline of information about how the crisis is  
7 proceeding.

8 Q. The -- the crisis of drug -- the  
9 drug crisis?

10 A. Yes.

11 Q. That includes --

12 A. The opioid crisis.

13 Q. The what?

14 A. The opioid crisis. Right.

15 Q. Is cocaine an opioid?

16 A. No.

17 Q. What does it say on the front page?

18 A. It's says heroin, fentanyl and  
19 cocaine.

20 Q. Right.

21 So it's doing more than just talking  
22 about the opioid crisis, right?

23 MR. GALLUCCI: Object to form.

24 THE WITNESS: As we discussed, the  
25 upswing in cocaine was due mainly to fentanyl.

1 But yes, I take your meaning that cocaine is  
2 not an opioid.

3 BY MR. CHEFFO:

4 Q. Okay. And -- and if we were to look  
5 back at your computer, this is a document that  
6 you maintain and update and compile based on  
7 information that's available to the department  
8 and other information that you may get from  
9 other departments, right?

10 A. Yes.

11 Q. Would you consider yourself the  
12 primary author of this document?

13 A. Yes.

14 Q. Would you follow me to the second  
15 page, which is the first page after the cover.

16 A. Uh-huh. Yes.

17 Q. And -- and I apologize. Just go  
18 back to the first page.

19 It says "December Update," the  
20 2000...

21 Was his previously promulgated?

22 A. No. I believe every month we  
23 just -- we put update. It's the November  
24 update from October, the December update --

25 Q. I see.



1           A.       -- from November.

2           Q.       So this is kind of a -- a monthly  
3 update document, right?

4           A.       Yes. I believe we've got them on  
5 our web site going back almost three years now.

6           Q.       Okay. So let's just look at the --  
7 the second page now, which is the first full  
8 page. Just a few issues.

9                    The -- the orange has total drug  
10 overdose deaths, right?

11          A.       Yes.

12          Q.       That's all -- all drugs that you  
13 capture that you've -- you know, you've  
14 identified as being part of the cause of death?

15          A.       The mode of death.

16          Q.       The mode of death. Okay.

17                   And then there are various other  
18 graph endpoints that are defined below,  
19 including heroin, cocaine, carfentanil,  
20 fentanyl and all opioids, right?

21          A.       Yes.

22          Q.       And I think we've talked about this  
23 with Dr. Gilson but make sure you understand  
24 this or -- or agree with this.

25                   There -- if -- if an individual has

1 two or three drugs in their system, it -- it  
2 may be listed multiple times, so you may have  
3 more drugs in a particular year than actual  
4 deaths; is that right?

5 MR. GALLUCCI: Object to form.

6 BY MR. CHEFFO:

7 Q. Do you understand my question?

8 A. So people will have multiple drugs  
9 in their systems, yes. They are counted in  
10 each category that's appropriate and  
11 identified. So you -- and I believe we talked  
12 about this earlier. You can't go through and  
13 add these all up and get the number at the top,  
14 no.

15 Q. Right.

16 So if you add them up, you're going  
17 to get more than the number on the bottom, and  
18 that's because there's essentially a double  
19 counting or triple counting, depending on how  
20 many drugs are found in the system?

21 A. Correct.

22 Q. Okay. So in terms of the line in  
23 2011 for fentanyl -- do you see that?

24 A. Yes.

25 Q. That's -- and also -- and what I

1 really want to focus on -- I apologize -- is  
2 actually the all opioids.

3 I think that's -- is that the 113  
4 number?

5 A. In 2011?

6 Q. Correct.

7 A. In 2011 it's, yes, 113.

8 Q. And that's prescription medicines,  
9 right?

10 A. Correct.

11 Q. And -- and just to be clear, on this  
12 chart prescription medicines don't -- this  
13 doesn't necessarily mean that they were  
14 lawfully prescribed; it just means that it's a  
15 medicine that can be lawfully prescribed if a  
16 doctor determines that it's appropriate.

17 A. Correct.

18 MR. GALLUCCI: Object to form.

19 BY MR. CHEFFO:

20 Q. So if a -- if a -- if -- if  
21 oxycodone or hydrocodone were diverted and  
22 found, it would still be deemed a prescription  
23 medicine, right, for the purpose of this chart?

24 MR. GALLUCCI: Object to form.

25 THE WITNESS: Correct.

1 BY MR. CHEFFO:

2 Q. And deaths related to prescription  
3 opioids were at their height in 2011, right?

4 A. Based on this time frame, yes.

5 Q. Well, this time frame goes from 2006  
6 to 2018, right?

7 A. Yes.

8 Q. So for that 12-year period, in any  
9 year the highest -- the highest number of  
10 prescription drug related death was 113, right?

11 MR. GALLUCCI: Object to form.

12 THE WITNESS: Correct.

13 BY MR. CHEFFO:

14 Q. And in 2018 they -- they dropped  
15 precipitously to 67, right?

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: That's the current  
18 projection, yes.

19 BY MR. CHEFFO:

20 Q. And in 2016, when there was a spike  
21 of total drug overdose deaths, the prescription  
22 drug deaths were lower than they were in 2011,  
23 right?

24 MR. GALLUCCI: Object to form.

25 THE WITNESS: Correct.

1 BY MR. CHEFFO:

2 Q. And then, if you look in 2016,  
3 that's the year where we see total overdose  
4 deaths go from 370 to 8 -- I'm sorry -- 666?

5 A. Correct.

6 Q. And that is largely, if not almost  
7 exclusively, driven by illegal opioids, right?

8 MR. GALLUCCI: Object to form.

9 THE WITNESS: It seems to be almost,  
10 right, one-for-one driven by illicit fentanyl,  
11 yes.

12 BY MR. CHEFFO:

13 Q. And same for 2016 to '17, that  
14 increase of 666 to 727 was also driven by  
15 almost exclusively illicit fentanyl, right?

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: Yes. To some extent,  
18 yes.

19 BY MR. CHEFFO:

20 Q. It was also driven by cocaine,  
21 right, in that years -- in those years?

22 A. I would have to see an -- a -- a  
23 different chart, a similar chart. But we do  
24 track nonfentanyl-involved cocaine deaths. And  
25 as I think I indicated before, we haven't seen

1 a lot of fluctuation in that number.

2 So most of the increase that you're  
3 seeing in cocaine deaths in '16 and '17 are  
4 almost all commingled with the fentanyl. So  
5 the fentanyl increase and the cocaine increase  
6 coincide because they're mixed together.

7 Q. And this is all illegal, illicit  
8 fentanyl, right?

9 A. Yes.

10 Q. And there's data or information in  
11 your office that breaks down and shows the  
12 commingled cocaine and fentanyl deaths?

13 A. Yes. We -- we do track that.

14 Q. And it's your belief that -- well,  
15 strike that.

16 Is it your belief that virtually one  
17 to one any increase over what was the baseline  
18 of cocaine deaths from 2016 to 2018 was  
19 attributable to a commingling of the illicit  
20 fentanyl and cocaine?

21 MR. GALLUCCI: Object to form.

22 THE WITNESS: Very nearly so, yes.

23 BY MR. CHEFFO:

24 Q. And -- and I think we -- I asked you  
25 earlier about the number of individuals who had

1       fentanyl-related deaths in 2016 and '17. I  
2       think you said there were just a handful of  
3       those that were associated with prescription  
4       fentanyl.

5               Do you recall that?

6               MR. GALLUCCI: Object to form.

7               THE WITNESS: In '16 and '17?

8               MR. CHEFFO: Uh-huh.

9               THE WITNESS: Yes. Very few.

10              BY MR. CHEFFO:

11              Q.       And -- and by "few," five? six?  
12       seven?

13              A.       Might have been just single digits.

14              Q.       Single digits.

15                      So that means that, proportionally,  
16       98, 99 percent of the fentanyl-related overdose  
17       deaths were from illicit fentanyl.

18              A.       Yes.

19              Q.       And in your work on the task force  
20       or around the office, where did that illicit  
21       fentanyl come from?

22              MR. GALLUCCI: Object to form.

23              THE WITNESS: We are not able to  
24       identify it with the work that we've done in  
25       our office. That -- that kind of tracking

1 takes more time consuming testing.

2 I believe we send all of our results  
3 to ENFLIS that -- the DEA's kind of lab. And  
4 they're able to do more specific work like  
5 that.

6 As far as discussions at the task  
7 force, there -- early on in the fentanyl phase,  
8 there had been illicit manufacture within  
9 Mexico. But as -- as -- as time went, we are  
10 told that more and more have -- had been coming  
11 in from China.

12 BY MR. CHEFFO:

13 Q. So is it fair to say that the  
14 overwhelming amount of fentanyl that's come  
15 into Cuyahoga County in the last three or four  
16 years has come from some illegal source outside  
17 the United States, based on the information  
18 you've been given?

19 MR. GALLUCCI: Object to form.

20 THE WITNESS: That's the information  
21 that I've been made aware of, yes.

22 BY MR. CHEFFO:

23 Q. And you would agree with me -- well,  
24 strike that.

25 Would you agree with me that, other



1       than some fluctuations, the baseline of deaths  
2       from prescription drugs has been relatively  
3       similar from 2006 to 2018?

4               MR. GALLUCCI: Object to form.

5               THE WITNESS: Yeah. With the  
6       exception of -- well, the first part, I mean  
7       2006 to 2011, it does bounce around, but it has  
8       kind of gone steadily up. And then after 2011,  
9       seems to decrease a bit and level out, yeah,  
10      until this past year.

11              BY MR. CHEFFO:

12             Q.     And as I said, I'm not -- because,  
13       frankly, proportionally, right, an extra 30  
14       deaths is a lot of human beings. So it's --  
15       you know, there's probably -- it doesn't take a  
16       lot of deaths to change the proportions.

17                    But just as -- my -- visually it --  
18       it looks like, you know, a relatively straight,  
19       you know, kind of line, right?

20             A.     In comparison to some of --

21               MR. GALLUCCI: Object to form.

22               THE WITNESS: -- the other lines on  
23       the graphs, yes.

24              BY MR. CHEFFO:

25             Q.     Okay. And I guess what I was going

1 to say is, you know, you -- the reason why I  
2 was just asking that is you've talked about a  
3 baseline for cocaine prior to 2016, right?

4 A. Yes.

5 Q. And the baseline for cocaine is  
6 actually higher, other than maybe 2011, than it  
7 is for prescription medicines, right?

8 Other than when you get to 2016.

9 A. Yes. For the most part. Those  
10 exceptions, yes.

11 Q. But even that baseline, right -- so  
12 in 2015 there were 120 cocaine-related deaths,  
13 right -- or cocaine-involved deaths, right?

14 A. I'm sorry. What year was that?

15 Q. 2015. 119, it looks like.

16 Am I reading that right?

17 A. 115?

18 Q. Is it 115? I'm sorry.

19 Have there been ever -- ever been  
20 efforts that you're aware of to start a task  
21 force or specific efforts to addresses the  
22 cocaine deaths in Cuyahoga County that appear  
23 to be very consistent and over a hundred every  
24 single year for the last 12 years?

25 MR. GALLUCCI: Object to form.

1 THE WITNESS: Discussions in recent  
2 years, we have talked about cocaine and -- and  
3 the importance of addressing cocaine, again, in  
4 conjunction with fentanyl. But yes, that's  
5 become a more prominent discussion in the task  
6 force and with -- with community.

7 BY MR. CHEFFO:

8 Q. In 2016, do you know -- of the 370  
9 overdose deaths, do you know how many of them  
10 were cocaine-only deaths?

11 A. What year?

12 Q. 2015.

13 A. '15? Of the 370, there were 115  
14 cocaine-related deaths.

15 Q. Right.

16 Now -- and -- and you may or may not  
17 know this. So I'm just trying to find out,  
18 in -- in some of the information and details  
19 we've seen, it's -- it's often said and  
20 reported that most people who have  
21 opioid-related deaths, they have multiple drugs  
22 in their system.

23 Are you familiar with that data?

24 A. Yes.

25 Q. So you're -- you don't usually see

1       just hydrocodone or oxycodone or heroin or  
2       fentanyl; it's usually a little bit of a  
3       cocktail in many people, right?

4           A.       Correct.

5           Q.       And is -- is the same true for  
6       cocaine?

7                   In other words, people who overdose  
8       on cocaine, putting aside the lacing with  
9       fentanyl -- but prior to that, if you see a  
10      cocaine death, would we expect to see multiple  
11      drugs in the system?

12                  If you know.

13          A.       Yeah. I would have to refer back to  
14      the data to be -- to be sure.

15          Q.       Are you aware of -- well, strike  
16      that.

17                  I take it everybody would agree  
18      that, even though drug over death [sic] numbers  
19      are probably almost certainly too high for  
20      everyone's liking, it's good news to see a  
21      drop?

22                  MR. GALLUCCI: Object to form.

23                  THE WITNESS: Yes. They will  
24      welcome whatever progress we can make.

25                  BY MR. CHEFFO:

1           Q.     And has your department assessed any  
2 factors that have led to that drop?

3           A.     Again, the final rulings aren't  
4 complete. So this is still a projection based  
5 on our best information to date.

6                     I believe, when we are talking about  
7 the press conference that was held, one of the  
8 things that had been brought up was the kind of  
9 precipitous drop in carfentanil deaths. That  
10 certainly had an impact.

11          Q.     Do you think that the work that's  
12 being done by the Board of Health and the --  
13 the -- the U.S. Attorney's task force and  
14 others has actually made an impact?

15                   MR. GALLUCCI: Object to form.

16                   THE WITNESS: I believe it has.

17                   BY MR. CHEFFO:

18          Q.     And I take it you agree that  
19 governments and other agencies wouldn't  
20 continue to have task forces in place for six,  
21 seven, eight years if they thought that they  
22 were not effective, right?

23                   MR. GALLUCCI: Object to form.

24                   THE WITNESS: The -- the task force  
25 itself is kind of a voluntary thing. So people

1       just kind of have continued with it. I -- I  
2       believe everybody still sees value in it.

3               BY MR. CHEFFO:

4               Q.       Right.

5               These are -- these are busy people,  
6       yourself included, right?

7               A.       Yes.

8               Q.       If you thought your work was not  
9       important and had a positive impact, you  
10      probably would find something else to do,  
11      right?

12              A.       Likely.

13              Q.       And do you agree that there's been a  
14      good amount of publicity that has focused on  
15      appropriate prescribing and the concerns about  
16      opioid use?

17              MR. GALLUCCI: Object to form.

18              THE WITNESS: That has been one of  
19      the focuses.

20              BY MR. CHEFFO:

21              Q.       And that's been over the last few  
22      years, right?

23              MR. GALLUCCI: Object to form.

24              THE WITNESS: Correct.

25              BY MR. CHEFFO:

1           Q.     And do you think it's likely that  
2     doctors in Cuyahoga County who prescribe  
3     opioids as part of their the practice have,  
4     through these various initiatives and  
5     informational campaigns and medical boards,  
6     received substantial information about  
7     prescribing and other potential information  
8     about opioids?

9           MR. GALLUCCI:   Object to form.

10          THE WITNESS:   I believe so, yes.

11          BY MR. CHEFFO:

12          Q.     And that's kind of the goal, right?

13          A.     That is one of the goals, yes.

14          Q.     And that's been ongoing for a few  
15     years, right?

16          MR. GALLUCCI:   Object to form.

17          THE WITNESS:   Yes.

18          BY MR. CHEFFO:

19          Q.     And you also believe, I take it,  
20     that that information has -- is important so it  
21     can form the prescribing habits of doctors,  
22     right?

23          A.     I'm -- I'm not sure that "habits" is  
24     the correct word.

25          Q.     Prescribing practices.

1           A.       The -- the guidelines that have  
2       been -- been put out by various federal and  
3       state agencies I believe are designed to inform  
4       the practice of medicine with respect to the  
5       prescription of opioids.

6           Q.       Okay. And in any of your work,  
7       professional or personal, have you met any  
8       doctor in Cuyahoga County who advised you or  
9       indicated that he or she wrote a opioid  
10      prescription for an improper purpose?

11                   MR. GALLUCCI: Object to form.

12                   THE WITNESS: I have not had that  
13      discussion with any.

14                   BY MR. CHEFFO:

15           Q.       Has any doctor that you're aware of,  
16      in your personal or professional life, said  
17      that they wrote a -- a prescription for an  
18      opioid pain medicine because they were  
19      improperly influenced by a pharmaceutical  
20      company?

21           A.       I've not had any specific questions  
22      with doctor about their prescribing habits in  
23      any form.

24           Q.       And the same would be true for  
25      distributors: Are you aware of any



1 information -- did any doctor ever tell you  
2 that they received any information from a  
3 pharmacy or distributor that caused them to  
4 improperly write a -- a prescription for an  
5 opioid medicine?

6 MR. GALLUCCI: Object to form.

7 THE WITNESS: So do I have any  
8 information, or has any doctor told me that?

9 BY MR. CHEFFO:

10 Q. Has any doctor told you that?

11 MR. GALLUCCI: Same objection.

12 THE WITNESS: I have not had any  
13 discussions with doctors about their  
14 prescribing habits. Or practices. Sorry.

15 BY MR. CHEFFO:

16 Q. Can you turn back to the -- the 2017  
17 report for a minute. And I'm going to ask you  
18 to look at 2 -- Page 13, please.

19 A. I'm sorry. What number?

20 Q. 13, 1-3.

21 You see it talks about the Cuyahoga  
22 County opioid initiative?

23 A. The Opiate Initiative, yes.

24 Q. Do you know what that is?

25 A. That's basically the task force.

1 But it also probably encompasses any of the  
2 county activities specifically.

3 Q. Well, it's called the Cuyahoga  
4 County Opiate Initiative, right?

5 A. Correct.

6 Q. So it's specific to this county,  
7 right?

8 MR. GALLUCCI: Object to form.

9 THE WITNESS: Correct.

10 BY MR. CHEFFO:

11 Q. And it's -- in fact, it's in the  
12 county's medical examiner's statistical report,  
13 right?

14 A. Correct.

15 Q. And what it says is: "is a broad  
16 response to the ongoing public health emergency  
17 identified in 2011 by the Cuyahoga County  
18 Medical Examiner's Office."

19 Do you see that?

20 A. I do.

21 Q. And when did you first start at --  
22 in the office?

23 A. 2011.

24 Q. So when you started, that's when the  
25 Medical Examiner's Office identified an ongoing

1 public health emergency?

2 MR. GALLUCCI: Object to form.

3 THE WITNESS: No. It's probably  
4 better worded that that's when we identified  
5 the issue. At the time of the printing of  
6 this, we -- I believe we were characterizing it  
7 as a public health emergency.

8 BY MR. CHEFFO:

9 Q. I'm sorry. I don't understand that.

10 A. So the president of the United  
11 States declared a national health emergency in  
12 2018, which is when this was printed. So  
13 it's -- it's not --

14 Q. Where -- where does it say anything  
15 about the president?

16 A. It does not.

17 Q. It -- it says pretty clearly, does  
18 it not, that it's a broad response to the  
19 ongoing public health emergency identified not  
20 by the president but identified in 2011 by the  
21 Cuyahoga County medical examine [sic] office,  
22 right, through a careful review of statistics  
23 of violent, suspicious and sudden or unexpected  
24 deaths, such as overdose deaths, specifically  
25 those due to opioids over -- opioids and

1       heroin, right?

2                   MR. GALLUCCI: Object to form.

3                   THE WITNESS: That's what it says.

4                   BY MR. CHEFFO:

5       Q.       So is it wrong?

6       A.       So I said it's imprecise. So at the  
7       time of the printing of this document, the  
8       president had already declared a national  
9       health emergency. When Dr. Gilson and I  
10      arrived in 2011 is when we first started to  
11      notice the problem with heroin. That's what  
12      this is trying to convey. This language is  
13      imprecise.

14                  BY MR. CHEFFO:

15      Q.       Well, I'm -- not to quibble with  
16      you, sir, but it doesn't seem imprecise to me.  
17      It seems very precise. I don't see anything  
18      about the president here or 2018.

19                  Let me ask you this: If I look back  
20      at -- and I guess we can.

21                  Is this -- is this language in any  
22      other reports?

23                  MR. GALLUCCI: Object to form.

24                  And move to strike the initial  
25      portion of that.

1 THE WITNESS: I don't have the other  
2 reports in front of me.

3 BY MR. CHEFFO:

4 Q. Okay. Okay. So what is it in 2000  
5 -- well, let me strike that.

6 When -- did the opioid -- the  
7 Cuyahoga County Opioid Initiative start in  
8 2011?

9 MR. GALLUCCI: Object to form.

10 THE WITNESS: Again, that's kind of  
11 a generic term. But yes, that was the  
12 beginning of our discussions internally, the  
13 Medical Examiner's Office, that we had noticed  
14 an increase in heroin deaths.

15 Going into 2012 we started to call  
16 some of the partners who were working on drug  
17 addiction issues, like the ADAMHS Board, the  
18 Board of Health, the U.S. Attorney's Office.  
19 And those were kind of the embryonic stages of  
20 putting together the task force.

21 In September of 2012 I believe is  
22 when the first kind of public pronouncement  
23 from the county executive and the medical  
24 examiner that we had identified a significant  
25 statistical increase in heroin deaths.

1                   And 2013 is when the task force was  
2                   kind of initiated.

3                   BY MR. CHEFFO:

4                   Q.       So there was a review of statistics,  
5                   death data, violence data, drug use in 2011  
6                   that put you and the county on notice; and  
7                   that's why you then started the opioid --  
8                   opioid initiative as well as the task force,  
9                   right?

10                  MR. GALLUCCI:   Object to form.

11                  THE WITNESS:   No.

12                  So we had general numbers.   We did  
13                  not have full reviews or analysis until much  
14                  later.

15                  BY MR. CHEFFO:

16                  Q.       But you -- you had enough  
17                  information to start an -- an -- an initiative  
18                  that you're actually touting, right, on Page 13  
19                  of your report, right, as a positive thing?

20                  A.       We had an awareness that there were  
21                  increased heroin numbers, yes.

22                  Q.       Right.

23                  So you had an awareness that puts  
24                  you on notice that there was a problem, right?

25                  MR. GALLUCCI:   Object to form.

1  
2 THE WITNESS: Well, it didn't put us  
3 on notice. Medical Examiner's Office was  
4 telling the public that we had a statistical  
5 increase in the number of heroin deaths.

6 BY MR. CHEFFO:

7 Q. Okay. So the Medical Examiner's  
8 Office put the public and other agencies on  
9 notice of a problem that it was seeing in 2011,  
10 right?

11 A. Well, the announcement wasn't until  
12 September of 2012.

13 Q. Okay. But you had -- you had made  
14 that determination, your office, back in 2011,  
15 as stated on Page 13 of the document, right?

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: Internally I believe  
18 that's the first time that we noticed that  
19 there were statistical numbers that needed --  
20 needed to be reviewed, yes.

21 BY MR. CHEFFO:

22 Q. So -- so --

23 MR. CHEFFO: Can I have this  
24 document. 15.

25 BY MR. CHEFFO:

1           Q.       So your testimony is that that  
2       language was imprecise because it really meant  
3       to say that you picked that up after the  
4       president's public health emergency, right?

5           MR. GALLUCCI:   Object to form.

6           THE WITNESS:   Well, it certainly was  
7       a -- a fact at time of the printing that the  
8       president had declared a national public health  
9       emergency.

10           I think in 2015 or '16 -- probably  
11       2016, because that's when the crisis really  
12       started to hit -- internally we tried to start  
13       using stronger language to make sure that  
14       people understood that there was more than just  
15       an awareness issue, that it -- that it was a  
16       serious crisis.

17           BY MR. CHEFFO:

18           Q.       So if I told you you used the words  
19       "ongoing public health emergency" in 2015 and  
20       '16, does that sound right?

21           MR. GALLUCCI:   Object to form.

22           THE WITNESS:   I don't know what  
23       you're referring to specifically.

24           BY MR. CHEFFO:

25           Q.       I can show it to you, but I'll read



1       it. This is from 2016, the same sentence:  
2       "The Cuyahoga County Opioid Initiative is a  
3       broad response to the ongoing public health  
4       emergency identified in 2011 by the Cuyahoga  
5       County Medical Examiner's Office."

6           A.       It's --

7                   MR. GALLUCCI: Object to form.

8                   BY MR. CHEFFO:

9           Q.       Does that ring a bell?

10          A.       So are you talking about the 2016  
11       statistical report?

12          Q.       Yes, sir.

13          A.       Okay. So I believe we talked about  
14       this before, is that the reports had been  
15       delayed. We actually completed the 2015, 2016  
16       reports in 2018. And the 2017 report, most of  
17       the work had been done in 2018 and had been  
18       published online in -- just a few weeks ago.

19          Q.       Okay. But if I look back -- and I  
20       can mark them, but I'm trying to save a few  
21       trees. But you're welcome to.

22                   So if I look at 2015 and I look at  
23       2016 and I look at 2017, it's the exact same  
24       language.

25                   Does that surprise you?

1           A.       No. As I said, all three of those  
2 books were completed in the calendar year 2018.  
3 So it doesn't surprise me.

4           Q.       And they all say "Ongoing public  
5 health emergency identified in 2011."

6           A.       So again --

7                   MR. GALLUCCI: Object to form.

8                   THE WITNESS: I --

9                   MR. GALLUCCI: Object to form.

10                   Is there a question?

11                   MR. CHEFFO: Yeah.

12                   BY MR. CHEFFO:

13           Q.       They do, right?

14           A.       They do.

15           Q.       They do say what I just read?

16           A.       They do. As I stated earlier, the  
17 language is imprecise. The -- the issue became  
18 a -- we became aware of the issue in 2011.  
19 Public health emergency had been declared by  
20 the president in 2018.

21           Q.       So in the next version, how -- how  
22 would you rewrite it to make it accurate?

23                   MR. GALLUCCI: Object to form.

24                   THE WITNESS: You're asking me to  
25 wordsmith on the fly here, so...

1                   Perhaps something along the lines  
2           of: The Cuyahoga County Opiate Initiative is a  
3           broad response first identified in 2011 by the  
4           Cuyahoga County Medical Examiner's Office  
5           through a review of overdose deaths,  
6           specifically those due to opiates, opioids,  
7           heroin and fentanyl that is now a public health  
8           emergency. But...

9                   BY MR. CHEFFO:

10           Q.       So is your -- is your issue with  
11           you -- you don't want to adopt that -- strike  
12           that.

13                   I should say you believe that it's  
14           not accurate to say that you -- there was a  
15           public health emergency in 2011?

16                   Is that your -- what you're --  
17           you're taking issue with?

18                   MR. GALLUCCI: Object to form.

19                   THE WITNESS: Well, I don't make  
20           those declarations. But like I said, we  
21           identified that there was an issue with an  
22           increase in heroin deaths at the end of 2011.

23                   BY MR. CHEFFO:

24           Q.       But was there -- I mean putting that  
25           aside, putting the words aside, was there a

1 public health emergency back in 2011 such that  
2 you formed a task force, you started looking at  
3 statistics, you got a bunch of the agencies  
4 together, you participated?

5 A. So we identified the increase in  
6 heroin deaths in late 2011. We were able to  
7 confirm the increase once all the cases were  
8 ruled in 2012.

9 We then started talking to people  
10 who had been dealing with drug issues  
11 throughout that year to the point where the  
12 county executive and the medical examiner  
13 decided to talk about the heroin issue in 2012  
14 in September. And in 2013 we assembled what  
15 would become the task force initially to put  
16 together a community summit at -- in November  
17 of 2013.

18 Q. So look back, if you would, at  
19 the -- the Medical Examiner's Office heroin,  
20 fentanyl, cocaine document. Same page. Page 2  
21 with the graph.

22 The blue is heroin, right?

23 A. The dark blue.

24 Q. I think so. The one right -- the  
25 second highest.

1           A.       No.   That's all opiate, opioid  
2       deaths.   This is a poor choice of colors, I  
3       believe.

4           Q.       Okay.   Okay.   So there was a -- so  
5       in 2007 there was a -- a jump of heroin deaths  
6       from 40 to 64, right?

7           A.       From 2007 to 2008, yes.

8           Q.       That's a what percentage increase?  
9       Like --

10           MR. GALLUCCI:   Object to form.

11           THE WITNESS:   Making me do a lot  
12       of --

13           MR. CHEFFO:   Okay.   It's -- it's --  
14       it's --

15           THE WITNESS:   -- math on the fly,  
16       too, here.   24, 40.   You know, it's more than  
17       50 percent.

18           BY MR. CHEFFO:

19           Q.       More than 50 percent.

20                   And then it remained the same for  
21       the next year in 2009, right?

22           A.       Yes.

23           Q.       And then it jumped to -- am I  
24       reading that right?   Is it 91?

25           A.       91.

1           Q.       So that's another probably -- rough  
2 math -- 30 percent increase?

3           A.       Roughly.

4           Q.       So your office and others were on  
5 notice of a substantial increase over the --  
6 the -- the years prior to 2011 in heroin,  
7 right?

8                   MR. GALLUCCI: Object to form.

9                   THE WITNESS: I was not in the  
10 office at that time. I couldn't say.

11                  BY MR. CHEFFO:

12           Q.       Do -- did anyone -- were -- are you  
13 aware of whether anyone paid attention to that  
14 before your joining?

15                   MR. GALLUCCI: Object to form.

16                   THE WITNESS: As I said, I wasn't  
17 there. I don't have any information.

18                  BY MR. CHEFFO:

19           Q.       I understand. But sometimes you get  
20 legacy information, a memo, talking to someone.

21                   Did you hear of any initiatives --  
22 or anyone talk and say -- or see a memo from a  
23 long-time employee or former employee who said,  
24 "Gosh, we were really concerned back in 2007  
25 when it jumped 50 percent. And then back in

1       2009 it jumped another 30, 40 percent"?

2               Are you aware of those  
3       conversations?

4               A.       I am not.

5               MR. GALLUCCI:   Object to form.

6               BY MR. CHEFFO:

7               Q.       And so -- and the progression of --  
8       of heroin use has been pretty steady from 2006  
9       on, right?

10              MR. GALLUCCI:   Object to form.

11              THE WITNESS:   Well, there was a  
12       decrease from 2006 to 2007.   But yes, there  
13       was -- and then it -- a flat -- it was a flat  
14       2008 to 2009.   But there's a general upward  
15       trend, yes.

16              MR. CHEFFO:   Okay.   Can we just mark  
17       that, please.

18              MR. GALLUCCI:   You know, we've been  
19       going for kind of -- about a hour 45.

20              MR. CHEFFO:   Oh, we have?   Is it --

21              MR. GALLUCCI:   All right.   If we  
22       take a break?   We had the --

23              MR. CHEFFO:   Yeah.

24              MR. GALLUCCI:   -- quick little  
25       reset, but we kind of came back --

1 MR. CHEFFO: That's okay.

2 MR. GALLUCCI: -- on at 1:24.

3 MR. CHEFFO: That's okay.

4 MR. GALLUCCI: Sorry. Take a quick  
5 break.

6 MR. CHEFFO: No. It's fine. It's a  
7 good -- good natural break.

8 MR. BORANIAN: Can we address  
9 something on the record before we go off.

10 We're learning now that there was  
11 another productions of documents from -- from  
12 county on Tuesday night between 11:00 and 12:00  
13 p.m., about 35,000 additional pages, including  
14 documents from Mr. Shannon's custodial file.

15 So I have two things to say. First,  
16 if you would please look into that on the break  
17 maybe.

18 MR. GALLUCCI: Which production  
19 number are you referring to?

20 MR. BORANIAN: We'll get that to  
21 you. 91. I'm being told it's 91.

22 But if you could inquire about that  
23 and let us know preliminarily what you can,  
24 we'd appreciate it.

25 And the second thing is that the



1 reservation of rights that Mr. Cheffo stated  
2 earlier, I wanted to clarify that -- that goes  
3 for all defendants, including the right to  
4 reopen this deposition if we deem necessary.

5 MR. GALLUCCI: Okay. And I  
6 understand the reservation you're making. I  
7 know earlier on the record we said that there  
8 was no identification of what it is. I'm  
9 looking. 91, much like 89, does say that it's  
10 further disclosure based on privilege review of  
11 custodial files. So it's the same thing as 89.

12 MR. BORANIAN: Okay. If there's any  
13 additional information you glean during the  
14 break, then let us know.

15 MR. GALLUCCI: That -- that's all  
16 I'm going to be able to have for you. It's  
17 additional documents that were produced after  
18 our rereview of privilege based on the  
19 instructions from the Court.

20 MR. BORANIAN: Thank you.

21 THE VIDEOGRAPHER: We are going off  
22 the record.

23 This is the end of Media Unit No. 4.

24 The time is 2:59.

25 (A short recess was taken.)

1 THE VIDEOGRAPHER: We are going back  
2 on the record.

3 This is the start of Media Unit No.  
4 5.

5 The time is 3:40.

6 You may proceed, Counsel.

7 MR. GALLUCCI: So during the break,  
8 counsel had the opportunity to speak. We've  
9 talked previously about Cuyahoga County's  
10 productions No. 89 and 91. I believe they were  
11 which -- were custodial documents, some of  
12 which contained documents from Mr. Shannon as  
13 well as Dr. Gilson. There's also apparently  
14 been some recent production by Purdue and, as  
15 we suspect, across many of the parties in light  
16 of some of the recent discussions that have  
17 taken place with the Court and Special Master  
18 relative to privilege.

19 The parties have discussed trying to  
20 work out an amicable solution. And we have  
21 agreed that, for purposes of Mr. Shannon's  
22 depo, due to the disclosure of additional  
23 documents within the past few days, that there  
24 will be a total time that defense will be able  
25 to use of eight hours of tape time, so one hour

1 more than as called for by the deposition  
2 protocol.

3 We will continue to move forward  
4 here today up until the mark -- the seven-hour  
5 mark, whatever amount they choose to use.  
6 Whatever's remaining balance they will have the  
7 right to use when we reconvene.

8 We further discussed with regards to  
9 Dr. Gilson that seven hours has already been  
10 used. Upon review of the additional documents  
11 that have been produced, should defense counsel  
12 desire to reconvene the deposition for up to an  
13 additional hour in the event that some of those  
14 documents are new documents they would not have  
15 had the opportunity to examine him on  
16 previously, plaintiffs will agree to the  
17 additional hour and will convene that at a  
18 mutually agreeable date in the relatively near  
19 future.

20 Is that everybody's understanding?

21 MR. CHEFFO: Yeah. I think  
22 that's -- that's our -- I think I can speak for  
23 the defendants. That's a -- a fair  
24 representation. And we agree and appreciate  
25 your -- your cooperation in trying to be as

1 efficient as we can.

2 MR. GALLUCCI: The only other thing  
3 I'd like to add is we did say that this was  
4 going to be agreement whether -- relative to  
5 these two depositions. However, anything --

6 MR. CHEFFO: Yeah.

7 MR. GALLUCCI: -- else that may be  
8 going on in the litigation is certainly to be  
9 determined.

10 MR. CHEFFO: Right. We -- I think  
11 we -- absolutely. And we agree that this is  
12 not a precedent either way for any other  
13 issues. This is a lawyers attempt to reach a  
14 practical solution in connection with the issue  
15 in front of us.

16 MR. GALLUCCI: Okay. Thank you for  
17 your cooperation.

18 MR. CHEFFO: Okay. We are back on.

19 BY MR. CHEFFO:

20 Q. Now, sir, as you probably heard,  
21 we're going to go another, you know, half hour,  
22 40 minutes. I'm going to try and ask some kind  
23 of specific, targeted questions. So if you  
24 don't understand, let me know. But if you'd  
25 work with me and try and listen to the

1 question, I -- I would appreciate it so we can  
2 kind of move through some of these.

3 So as you sit here today, in  
4 connection with the -- the budget or  
5 anticipated costs for 2019, are you aware of  
6 any specific line items or allocations that  
7 have been made for opioid-related costs that  
8 your department will have to bear?

9 A. For 2019, again, there are things  
10 that are already embedded in the budget. And  
11 it's not -- our budgeting is not in line item.  
12 They'll be kind of under certain subobject  
13 codes for contracts or whatnot.

14 So we do have to send some  
15 toxicology out to testing -- other testing  
16 facilities who have a broader spectrum of  
17 standards. And they're able to detect kind of  
18 the specialty, novel type opioids. That will  
19 continue in 2019. So technically, that will be  
20 in that budget somewhere.

21 Something new that we haven't  
22 already, you know, had in our budget  
23 previously -- I'm not aware of any -- but  
24 we're, again, going to be able to review 2018's  
25 budget and -- and make some determination going

1 from -- forward from there.

2 Q. And other than the testing that you  
3 just talked about, is there anything else that  
4 you can think of that you're currently aware  
5 of?

6 A. That are specifically  
7 opioid-related?

8 Q. Yes, sir.

9 A. Nothing in comes to mind. I have to  
10 review, you know --

11 Q. Okay.

12 A. -- the budget.

13 Q. And -- and am I correct that -- that  
14 if I asked you "Do you have any expected  
15 expenses related to opioids coming up in 2020,  
16 2021, 2022?" would your answer be you're not  
17 aware of any as you sit here?

18 A. Yeah. I mean once we get into the  
19 next biennium, we'll have to do an assessment  
20 of where we're at, whether, you know, the trend  
21 that we saw last year continues, and make  
22 adjustments from there.

23 I can tell you already January looks  
24 like -- worse than 2017 right now. So I said  
25 it will be a constant monitoring and assessment

1 as we go forward. 2020, '21, '22 is way too  
2 far down the road to make any decisions about  
3 right now.

4 Q. When you say January looks worse, is  
5 that -- there's -- there's a -- an uptick in  
6 overdose deaths?

7 A. Yes.

8 Q. Do you know what it's attributed to,  
9 what -- what drugs?

10 A. No, not yet.

11 Q. Okay. Do you have any order of  
12 magnitude?

13 A. Two deaths a day.

14 Q. And where does that fit in the --  
15 the normal range or the baseline range?

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: It depends on what  
18 you're saying baseline is. It's currently the  
19 highest -- if it projected out over the entire  
20 year, it would be worse than 2017.

21 BY MR. CHEFFO:

22 Q. Okay. Now, can you look at that  
23 large printout document, please.

24 A. Which?

25 Q. Yeah. Sorry. The --

1 A. The report or the budget?

2 Q. The financial expenditure report.

3 A. Okay. Thanks.

4 Q. So if you could turn to the areas in  
5 the medical examiner operations.

6 MR. GALLUCCI: I'm just going to  
7 note an objection. I believe, when there  
8 weren't copies of this, you indicated you  
9 weren't asking specific questions on it.

10 MR. CHEFFO: You are correct.

11 We -- we can give you a copy. I  
12 mean --

13 MS. NEWMARK: It's on the thumb  
14 drive that I gave you.

15 MR. CHEFFO: I mean --

16 MS. NEWMARK: And then --

17 MR. CHEFFO: So -- so it -- it's  
18 fair. And I -- I -- so here's what I would  
19 say, Frank. I mean I --

20 MR. BORANIAN: There are copies of  
21 the excerpts at which Mark is looking attached  
22 to those. You have it in your hand. They're  
23 copies.

24 MR. CHEFFO: Oh, these are copies?  
25 Okay. So -- so --



1 MR. GALLUCCI: Yeah. I -- I was  
2 going to say ask, and let's see.

3 MR. CHEFFO: Yeah. No. You know  
4 what? He doesn't even need to look at that,  
5 right? He can look at this.

6 MR. BORANIAN: He can.

7 MR. CHEFFO: Right?

8 MS. NEWMARK: Yes.

9 MR. CHEFFO: Okay. So let's just  
10 mark this. No. It's fair. I --

11 MR. GALLUCCI: And we'll proceed  
12 with the excerpts but, for the record, note  
13 that the entire exhibit's not being provided.

14 MR. CHEFFO: Right.

15 MR. GALLUCCI: Do we want to mark  
16 the excerpt?

17 MR. CHEFFO: Yeah. I think she's  
18 marking it.

19 MR. GALLUCCI: But do we want to  
20 mark it as subset of 3, or --

21 MR. CHEFFO: No. Just --

22 MR. GALLUCCI: -- do you want to  
23 keep going?

24 MR. CHEFFO: Just mark it as another  
25 exhibit.

1 (Deposition Exhibit 7 was marked for  
2 identification.)

3 BY MR. CHEFFO:

4 Q. So, sir, this is a -- a subset of  
5 the expenditure information just related to the  
6 medical examiner operations.

7 See that?

8 A. That's what's it says on --

9 Q. Okay.

10 A. -- on the page here, yes.

11 Q. If you look at the second page of  
12 the document -- one, two, three -- one, two,  
13 three, four -- five from the bottom, "Cuyahoga  
14 County region forensic science laboratory."

15 Do you see that?

16 A. I do.

17 Q. What is that funding for?

18 A. The regional forensic science lab.

19 Q. Everything related to the science  
20 lab?

21 A. For the most part, yes.

22 MR. GALLUCCI: And, counsel, for the  
23 record, I just want to note that the subset  
24 that we're now marking Exhibit 7 has five  
25 columns on it. The complete exhibit has

1       whatever -- there's one before A, all the way  
2       through S. So it does not appear to be --

3               MR. BORANIAN: The -- the remaining  
4       columns are on subsequent pages of Exhibit 7.  
5       We printed it on this size paper for  
6       manageability and for readability. But the  
7       columns are all there.

8               MR. GALLUCCI: Okay. So Page 2 is  
9       one part of it, but page later in the document  
10      is still part of what he's being referred to?

11              MR. BORANIAN: That's correct.

12              Mr. Shannon, is that what it looks  
13      like to you?

14              MR. GALLUCCI: Okay.

15              THE WITNESS: It -- it looks like  
16      there are additional columns further back in  
17      the document. It's a little hard to follow  
18      this way, but -- and it doesn't appear to have  
19      any headers at the top. So I'm not sure.

20              MR. GALLUCCI: I guess, if you would  
21      be cognizant of -- as you ask questions. It  
22      appears that there's a total of 12 pages in  
23      Exhibit 7, and maybe each column is represented  
24      by three pages. So probably Page 1, Page 5 and  
25      Page 9, I'm guessing --

1 MR. CHEFFO: Yep.

2 MR. GALLUCCI: -- would line up,  
3 but...

4 MR. CHEFFO: I only have a very few  
5 questions. So -- but -- and look, if you need  
6 to look at that document, if you can't tell,  
7 you'll just tell me, as you have throughout the  
8 deposition.

9 And I -- I apologize. It's -- it is  
10 a little challenging to read, but that's only  
11 because it's an Excel spreadsheet.

12 BY MR. CHEFFO:

13 Q. So the -- the forensic science lab  
14 line items are all funding for the science lab,  
15 right?

16 A. Yes.

17 Q. And then, for the medical examiner  
18 lab fund, which is below that, and it says  
19 "Coroner's Lab," what are all those entries  
20 related to?

21 A. Again, I think, as I -- I stated  
22 earlier, we have it divided up into three pots:  
23 the general operating, the forensic lab, and  
24 then what we call the ME lab.

25 That's the statutory creation that

1 we generally use funds from our contracts with  
2 other agencies to do their autopsies. And  
3 we're able to utilize that to replace equipment  
4 in the Medical Examiner's Office.

5 Q. Yeah.

6 And then there's one more. If you  
7 look on the -- I guess fourth page of the  
8 document, it says "Cuyahoga County" -- I don't  
9 know if that's regional or -- or -- R-E-G  
10 forensic lab.

11 Is that the third bucket?

12 A. I see it.

13 Q. It's right under where -- you know,  
14 in -- in another column, in the second column,  
15 it says "Corner's Lab," right, on the fourth  
16 page for the first six or seven entries. And  
17 then right below it there's a new entry. It  
18 changes.

19 Do you see that?

20 A. I do.

21 Q. And I'm just -- would like you to  
22 tell us what that represents.

23 A. To be honest, I haven't seen  
24 anything characterized this way before. So I'm  
25 having trouble differentiating this Cuyahoga

1 County regional forensic science lab SR from  
2 Cuyahoga County region forensic science lab.

3 I'm -- I'm not sure what that  
4 designation actually is or how it  
5 differentiates.

6 Q. Okay. Who would be the person to  
7 answer that question if you wanted to know the  
8 answer?

9 MR. GALLUCCI: Object to form.

10 THE WITNESS: I would likely call my  
11 budget analyst --

12 BY MR. CHEFFO:

13 Q. And who is that?

14 A. -- at OBM.

15 Either Chuck Cavano or Anthony  
16 Henderson.

17 Q. And if you take a minute just to  
18 look at -- your counsel appropriately pointed  
19 out that there's some other pages here. Just  
20 the way it works.

21 A. Yes.

22 Q. If you want to just take a minute  
23 and look at the -- the correlating or the --  
24 the matching documents to this forth page, see  
25 if that helps you. So it probably should be 8.

1 MR. GALLUCCI: Should be.

2 MR. CHEFFO: 8 and 12.

3 THE WITNESS: I'm going to have  
4 to -- it'd be a lot easier if I look at this,  
5 assuming that you're stipulating that this  
6 comes from this, it's all the same.

7 MR. CHEFFO: That's my  
8 understanding.

9 MR. GALLUCCI: Do you know where in  
10 the -- in Exhibit 3 this could be found? Is  
11 there somewhere you can point him to so that  
12 it's --

13 MR. CHEFFO: It should be in the red  
14 portion.

15 MS. NEWMARK: It's the --

16 MR. BORANIAN: In the parts that we  
17 highlighted previously.

18 MR. CHEFFO: Yeah. I think there's  
19 only a few pages there.

20 THE WITNESS: So Cuyahoga County  
21 regional forensic science lab SR appears to be  
22 the -- the -- the third bucket that I have been  
23 talking about. That is what pays salaries,  
24 contracts, equipment, et cetera, for the  
25 forensic lab.

1                   This piece here, Cuyahoga County  
2                   region forensic science lab general operating  
3                   fund, it appears that's only -- it only exists  
4                   in the 2011 column. And it appears to be a  
5                   number of different, you know, supplies and  
6                   whatnot. I can't tell from this.

7                   And again, I arrived in the middle  
8                   of 2011. So the 2011 budget had already been  
9                   set prior to my and Dr. Gilson's arrival. None  
10                  of this really rings any bells for me. So I --  
11                  I couldn't -- I couldn't speak to what that  
12                  represents.

13                  What I can say though is -- is that  
14                  the final portions here that are indicated as  
15                  Cuyahoga County regional forensic lab SR appear  
16                  to be the normal budget for the regional  
17                  forensic labs.

18                  MR. CHEFFO: Okay. Thank you. You  
19                  can put that away.

20                  Would you be good enough to reach  
21                  next to and -- the court reporter's going to  
22                  hand you that document.

23                  (Deposition Exhibit 6 was marked for  
24                  identification.)

25                  BY MR. CHEFFO:



1           Q.     Can you tell me what that is,  
2     please?

3           A.     This looks like the --

4                   MR. GALLUCCI:   What number did we  
5     mark this?

6                   THE REPORTER:   6.

7                   MR. GALLUCCI:   I'm sorry.

8                   MR. CHEFFO:    6.   Exhibit 6.

9                   THE WITNESS:   The final drug report  
10    for 2016.

11                  BY MR. CHEFFO:

12           Q.     Okay.   If you look at the second  
13    page.

14                   I think we talked a little earlier  
15    about nonfentanyl cocaine deaths?

16                   MR. GALLUCCI:   Sorry to interrupt,  
17    Counsel.   My copy has two -- it has a black-and  
18    white of the cover and a color.   The  
19    black-and-white has a Bates number, but then  
20    after that there are none.

21                   I don't know if that's the same as  
22    all the copies that have been distributed.

23                   THE WITNESS:   That's how mine is.

24                   MS. NEWMARK:   Yeah.   Because we were  
25    -- the produced version was blank-and-white.

1 And it's easier see it in color. So the color  
2 version was pulled off the web site -- the  
3 Cuyahoga County medical examiner web site.

4 It is the same as the version that  
5 was produced to us, only in color, because it's  
6 easier for everybody to see. So the Bates  
7 number reflects the produced version.

8 MR. GALLUCCI: And -- and again,  
9 there's a singular Bates number for the entire  
10 report?

11 MS. NEWMARK: That's the starting  
12 Bates number for the report.

13 MR. GALLUCCI: Okay.

14 BY MR. CHEFFO:

15 Q. And let me just ask you this is --  
16 this is a document that's on your web site,  
17 right?

18 A. Yes.

19 Q. And on the first page when it's  
20 marked "Confidential," is this a confidential  
21 document?

22 A. I don't believe that's anything that  
23 we put on there.

24 Q. Right.

25 So look at the -- the -- the first

1 page that has a chart, which is either the  
2 second -- or third page of the document, which  
3 is -- of this exhibit but the second page of  
4 the document. It says: "CCMEO 2016  
5 Fentanyl-Involved Deaths."

6 See that?

7 A. I do.

8 Q. And then there's a number of 119,  
9 fourth -- fifth bar over?

10 A. Yes.

11 Q. What does that represent, sir?

12 A. That represents all deaths that had  
13 cocaine associated with it but not fentanyl.

14 Q. For what year?

15 A. It would be 2016.

16 Q. In terms of -- is there -- is there  
17 something called a -- a -- a death database or  
18 a database that collects information on  
19 decedents or information?

20 A. So we have a decedent management  
21 system, yes.

22 Q. What is that called?

23 A. VertiQ, V-e-r-t-i cap Q.

24 Q. And what information does that  
25 store?

1           A.       All -- large variety really.  
2       Everything that we need to do to produce the  
3       autopsy reports, the death certificates. It  
4       will have your basic demographic data; next of  
5       kin; who reported the death; who, you know,  
6       found the body; what their relationship was to  
7       the decedent; a summary of the initial call; a  
8       summary of the investigative report; I couldn't  
9       just -- just about every -- all the doctors --  
10      notes to the doctor, notes to the  
11      investigators.

12                 We use it for final disposition;  
13      what funeral home; whether or not there's a  
14      progress form that'll say whether the body had  
15      been viewed, by whom, what time; has the  
16      autopsy be -- been done, by whom, what time,  
17      what day; is the body ready for release; is the  
18      body on hold for any reason; is the body going  
19      for organ donation; has the body been released;  
20      who picked up the body; who signed for it; is a  
21      toxicology report done; has a death certificate  
22      been issue; is it a pending death certificate  
23      or an original.

24                 If there is pending, then there'll  
25      be a supplemental. Has that been completed and

1       when.

2                       So there's just a --

3           Q.       A lot of information.

4           A.       -- large, large database of  
5       information.

6           Q.       And is this -- is this database --  
7       or strike that.

8                       Does this database link information?

9                       So, for example, if it says, you  
10       know, has a tox report been done, can I then  
11       click on some way to get the tox report; or do  
12       I have to go to another database?

13          A.       I wish. It'd be great if you could  
14       come up with that. No, it doesn't. We have a  
15       separate database for evidence. Anything  
16       relating to toxicology is part of the evidence  
17       chain, even though we release it with the  
18       autopsy report. That's in JusticeTrax,  
19       T-R-A-X. And currently those two do not speak  
20       the same language. And so we have to run the  
21       systems separately.

22          Q.       Is that true for other types of  
23       records, like not just tox but medical records  
24       or investigator reports; are they all  
25       maintained outside of VertiQ, or are any of the

1 documents and work being done by the department  
2 also accessible through VertiQ?

3 A. No. So -- and I have to -- I have  
4 to back up. So we're adding the JusticeTrax  
5 toxicology module now. It was supposed to be  
6 ready January 1st.

7 There was an in-home toxicology  
8 tracking system done, and we're -- we're  
9 replacing it. We're in the process of  
10 replacing it. So JusticeTrax handles all the  
11 evidence for the forensic lab. It does not yet  
12 do toxicology, but we've got the module that's  
13 currently stored in Pathway, as it's called.  
14 And that's done by one of our in-house IT.

15 So current toxicology is in  
16 Pathways. It's moving any day now to  
17 JusticeTrax.

18 I apologize.

19 Q. Okay.

20 A. I just -- I got ahead of myself.  
21 Was wishful thinking probably.

22 And I -- I forgot the rest of your  
23 question.

24 Q. No. That's okay. No. It's  
25 helpful.

1 I mean so -- but I -- I guess I just  
2 want to stick for a minute with VertiQ. I -- I  
3 --

4 A. Sure --

5 Q. -- don't want to put words in your  
6 mouth. You -- you gave us, helpfully, a long  
7 list of -- it sounded to me like important  
8 tracking information, right, to find out where  
9 the kind of decedent -- the investigation was  
10 in the -- in the process.

11 And I was just trying to understand  
12 if, other than just the tracking, if it said do  
13 we have medical records, or do we have a tox  
14 study, or do we have something --

15 A. Sure.

16 Q. -- whether I could then go into that  
17 system, or would I have to read VertiQ and say,  
18 "Yes, there are medical records. Now I got to  
19 go over here to get them"?

20 A. Right. So medical records is kind  
21 of a whole other ball of wax. Every hospital  
22 has an electronic medical records system. None  
23 of the hospitals have the same one. We  
24 obviously aren't part of the hospital systems.  
25 So we have actual printouts of the requested

1 medical reports.

2 There'll be a checkbox in VertiQ  
3 that says a report has been requested of who,  
4 by who, at what time, and whether it's been  
5 received or not, and when it was received. But  
6 that report will actually be in the physical  
7 paper file.

8 Q. Okay. So am I correct that VertiQ  
9 is -- is really just a tracking tool, albeit  
10 probably a helpful one; but if I want to drill  
11 down into anything -- correspondence,  
12 communication, records, documents, I have to go  
13 somewhere else?

14 A. Right. It will depend specifically  
15 what you're looking for. The VertiQ database  
16 is massive, but it does not include everything.  
17 And so -- right.

18 For evidentiary reports and things  
19 like that, you'd have to go to JusticeTrax.

20 For any of the correspondence -- say  
21 a -- an attorney is asking for X. That request  
22 gets put in the hard copy file. Those are  
23 eventually digitized and stored in various  
24 places, the physical copy in one place, the  
25 electronic in various databases and on disks.



1           Q.     And are they ever accessible through  
2 VertiQ?

3           A.     Are -- are what accessible?

4           Q.     Those digitized medical records or  
5 other records.

6           A.     So when a case file is closed, when  
7 work is being completed -- and it's usually  
8 about a 18-month lag -- paper files will sit in  
9 the file room in the building. Usually  
10 anything older than two years is put in  
11 archives.

12                     When it goes to archives, they're  
13 boxed, numbered. They sit. What we started  
14 doing, I think in 2012, was taking -- I think  
15 we took -- I think we had paper files back to  
16 the 1970s. We took those and started  
17 digitizing them. I think we've got about two  
18 decades worth now digitized. And they're on  
19 both the hard drive and a disk.

20                     But again, they don't  
21 cross-reference each other in any way. So for  
22 certain things you have to go to the physical  
23 file, for certain -- for evidence you have to  
24 go to JusticeTrax. For all the -- all the rest  
25 of it, it's housed in VertiQ.

1           Q.     Okay. So let me just give you a  
2 quick example.

3                     And so let's assume there's a  
4 checkmark that someone requested medical  
5 records from Hospital ABC.

6                     Will the -- the letter or the  
7 request for authorization be in VertiQ?

8           A.     The request for the report will be  
9 in VertiQ, yes.

10          Q.     Okay. And -- and you know what  
11 OARRS is, right?

12          A.     Yes.

13          Q.     Is -- is OARRS -- does OARRS  
14 interface in any way with VertiQ?

15          A.     It does not.

16          Q.     Who has access to VertiQ.

17                     Is it something that administrative  
18 people do or the doctors or everyone?

19          A.     Most everybody. A lot of the  
20 administrative work, both medical secretaries  
21 who are doing the autopsy reports. The case  
22 managers who are actually working on death  
23 certificates, burial permits, things like, have  
24 access to it. Obviously the doctors, the  
25 investigators have access to it.

1           Q.     Do you use it for any of the  
2     reporting and other kind of public policy work  
3     that you do?

4           A.     So we can download reports that we  
5     can utilize for those statistical reports for  
6     these reports.

7           Q.     So that's -- that's what I was going  
8     to ask you.

9                     So the kind of reports that we've  
10    been talking about in these exhibits, is that  
11    information that primarily comes from VertiQ?

12                    MR. GALLUCCI: Object to form.

13                    THE WITNESS: Some of it, yes.

14                    BY MR. CHEFFO:

15           Q.     What -- what information doesn't  
16     come from VertiQ?

17                     Or what are the other main sources  
18    of data or information outside of VertiQ?

19           A.     Well, for this specific report I  
20    said we've included information from the DAWN  
21    program. That has to be gotten separately.  
22    The different substances, that came from the  
23    forensic lab. These are from the analysis of  
24    the poison death reviews from '12, '13, '14  
25    that we talked about.

1                   So information that was used to  
2                   compile these came from a variety of different  
3                   sources --

4           Q.       And what page are you on, just for  
5           the record?

6           A.       The very last two pages.

7           Q.       Okay.

8           A.       A lot of it does come from VertiQ.  
9           And we're able to extract, you know, some of  
10           the basic information: cause of death, age,  
11           gender, race, things like that.

12          Q.       When people -- when -- when --  
13           professionals who are authorized to access  
14           OARRS, do they print out any of the  
15           information, put it in a file?

16          A.       In general we have not done that.  
17           There have been requests by medical staff made  
18           to be able to see them. So starting January  
19           1st of this year, we did start that practice.

20          Q.       Start what practice?

21          A.       That we would download a OARRS  
22           report for the doctors to review if there was  
23           one in the course of their investigation.

24          Q.       Is that -- that's like an SOP in all  
25           cases?

1 MR. GALLUCCI: Object to form.

2 THE WITNESS: So as I said, we just  
3 started this practice three weeks ago. We're I  
4 think still kind of getting our feet wet about  
5 how well it's working and whether it's worth  
6 doing. We have some questions we need to ask,  
7 both of our staff and the OARRS staff, to see  
8 if that's a practice that we're going to  
9 continue with.

10 BY MR. CHEFFO:

11 Q. And am I correct that you would --  
12 you would look for an OARRS report in all drug  
13 overdose cases but not in all cases generally?

14 Or would you look, as a matter of  
15 course, in all cases for an OARRS report?

16 MR. GALLUCCI: Object to form.

17 THE WITNESS: So currently we're  
18 downloading an OARRS report for every case,  
19 whether or not we have a suspected drug  
20 overdose or not. And there are cases where  
21 that's not readily obvious at the outset. And  
22 so, for -- to be thorough, I think we're  
23 starting with that practice.

24 Again, that's one of the things that  
25 we're discussing and evaluating on whether that

1 practice continues or not.

2 BY MR. CHEFFO:

3 Q. So just to be -- make sure I think  
4 the record's is clear.

5 So if somebody has a vehicular --  
6 vehicular accident or a fall as well as a  
7 overdose, the current practice that's been in  
8 place in the last two to three weeks is to do  
9 an OARRS report.

10 A. We'll review --

11 MR. GALLUCCI: Object to form.

12 THE WITNESS: -- to see if there's  
13 an OARRS report available. And if so, we'll --  
14 we'll download it.

15 BY MR. CHEFFO:

16 Q. Download it, print it out so that  
17 it's available to the doctor?

18 A. Correct.

19 Q. And if you look at Exhibit 6 as an  
20 example for a minute, please.

21 Is that a repeat of Exhibit 4, the  
22 2017 report?

23 A. Is Exhibit 6 the same as Exhibit 4?

24 Q. Some of the information.

25 A. These are not -- these are not the

1 same reports, no.

2 MR. CHEFFO: Yeah. Sorry. Bad  
3 question.

4 BY MR. CHEFFO:

5 Q. What -- what I'd like you to do --  
6 and again, you can handle them separately, if  
7 you'd like, if it's easier, or if you want to  
8 look at them together -- is really just find  
9 out, for both Exhibit 4 and Exhibit 6, what  
10 sources are used.

11 A. As I --

12 MR. GALLUCCI: Object to form.

13 THE WITNESS: As I said, Exhibit 6  
14 has multiple sources.

15 MR. CHEFFO: Okay.

16 THE WITNESS: Exhibit 4 is the  
17 statistical representation of the work done in  
18 2017. It includes drug overdoses, but it's not  
19 exclusive to --

20 MR. CHEFFO: All right.

21 THE WITNESS: -- drug overdoses.  
22 And this is compiled from a number of sources  
23 as well.

24 BY MR. CHEFFO:

25 Q. Okay. Would you -- to the extent

1       that you can tell us the main sources where  
2       it's pulled from, is VertiQ one of them?

3           A.       VertiQ.

4           MR. GALLUCCI:   Object to form.

5           THE WITNESS:   JusticeTrax.

6           MR. GALLUCCI:   Object to form.

7           THE WITNESS:   All right.

8           MR. GALLUCCI:   Go on.

9           THE WITNESS:   VertiQ, JusticeTrax,  
10       Pathways.

11           BY MR. CHEFFO:

12           Q.       What is Pathways?

13           A.       It's the current toxicology system  
14       that we're trying to get rid of and replace  
15       with the module in JusticeTrax.

16           Q.       And -- and JusticeTrax -- I  
17       apologize if you told me this -- what is --  
18       what is the main function of that?

19           A.       That's the -- that's our database  
20       that tracks evidence.

21           Q.       And evidence would include  
22       ultimately the toxicology as well as medical  
23       records and investigator information?

24           A.       No.

25           Q.       Okay.



1           A.     So toxicology will move to  
2 JusticeTrax.

3           Q.     Will move.

4           A.     Investigator reports is not -- not  
5 forensic evidence. Those are reports on  
6 observations by our investigators at scenes of  
7 death. Medical records are separate.

8           Q.     So let me ask you a better question.

9                     What does JusticeTrax do currently,  
10 understanding that they're going to move the --  
11 you're going to move the toxicology information  
12 into JusticeTrax, but currently what is it --  
13 what information does it -- how is it useful to  
14 your -- your group?

15          A.     All the other forensic evidence that  
16 gets submitted to the forensic laboratory.

17          Q.     Can you give us some examples of  
18 that?

19          A.     Guns, ammunition, shell casings,  
20 fingerprints, fibers found at crime screens,  
21 analysis of other materials found at crime  
22 scenes and death scenes, DNA, any substances  
23 that are submitted for testing in the drug  
24 chemistry laboratory.

25                     Like I said, it -- it's the largest

1 database in the county.

2 Q. And if -- if someone accesses --  
3 let's just start with any of these database --  
4 are there, to the extent that you're aware,  
5 records of who accesses them, inquiries that  
6 are made?

7 A. I believe that JusticeTrax and  
8 VertiQ both have the ability to track, yes.

9 Q. And by "track" it means both who  
10 accessed them, what time, for example, as well  
11 as if they printed anything out or made any  
12 changes?

13 MR. GALLUCCI: Object to form.

14 THE WITNESS: I'm not sure if it  
15 will show that anything gets printed out. But  
16 any additions or subtractions or changes are  
17 tracked.

18 BY MR. CHEFFO:

19 Q. And for the OARRS printouts that are  
20 done for all death cases, just tell -- where do  
21 they actually go once they're printed out?

22 A. They're going with the physical case  
23 file for the time being.

24 Q. And the physical case file goes to  
25 the medical examiner?

1           A.       It will go to the forensic  
2 pathologist whose case it was assigned, yeah.

3           Q.       And then what happens after that?

4           A.       Well, it's only been three weeks.  
5 So there hasn't been and after that yet.

6           Q.       Okay.

7           A.       None of the cases are closed out  
8 yet.

9           Q.       Fair.

10                  What -- what's the expectation?

11                  MR. GALLUCCI: Object to form.

12                  THE WITNESS: I think that's part of  
13 what we're discussing now is what -- what are  
14 the next steps. And that's part of what we're  
15 asking for -- from OARRS.

16                  BY MR. CHEFFO:

17           Q.       Who ws -- was Dr. Gilson the person  
18 who decided to put this policy in place?

19           A.       Yeah. He was the one who made the  
20 final decision, yes.

21           Q.       And when did he make that decision?

22           A.       I mean we had had discussion on and  
23 off in December. But I -- I believe it was  
24 around the first of the year.

25           Q.       And he said he thought it would be,

1 in sum or substance, appropriate to print out  
2 OARRS for all death cases?

3 MR. GALLUCCI: Object to form.

4 THE WITNESS: I believe that was my  
5 suggestion. There have been members of the  
6 medical staff who in other jurisdictions had  
7 had access to them and found OARRS reports or  
8 OARRS-like reports useful.

9 He wanted to facilitate that. Asked  
10 me to look into it, how we would implement  
11 that. I think the final, you know, decision  
12 that he made was still based on I thought it  
13 was best that we do it for all the cases for  
14 the time being just so nothing got missed.

15 Q. He -- he does autopsies, right?

16 A. Dr. Gilson?

17 Q. Yes, sir.

18 A. Yes, he does.

19 Q. In addition to his other  
20 responsibilities?

21 A. He does.

22 Q. So he has a certain number of cases  
23 that he handles, right?

24 A. He does.

25 Q. So he would have received these

1 OARRS -- he's taken cases in the last few  
2 weeks, I take it?

3 MR. GALLUCCI: Object to form.

4 THE WITNESS: I -- I would have to  
5 check the records. He doesn't do the same  
6 caseload as the regular medical staff because  
7 of his other duties.

8 So I -- he also is responsible for  
9 most of the case review cases. They're  
10 called -- they were called corner amendment  
11 cases originally, CA cases.

12 It's essentially anything that looks  
13 like it needs an extra review, not necessarily  
14 to bring full jurisdiction of the body to our  
15 office but to review on paper medical records,  
16 any other information we have to determine  
17 whether or not it would be best to bring that  
18 case in.

19 Usually something gets flagged say  
20 by a funeral home or what -- or a nursing home  
21 or something like that. We'll review it --  
22 he'll review it. And then they can make a  
23 determine -- a better determination whether the  
24 case needs to be brought in under our  
25 jurisdiction.

1 MR. CHEFFO: Okay.

2 THE WITNESS: We did about 500 of  
3 those reviews last years. He's primarily  
4 responsible for that.

5 So he may have cases like that,  
6 which we have not implemented OARRS reviews of  
7 CA cases as of now. We're just sticking to the  
8 IN cases, the cases that we're accepting  
9 jurisdiction of from Cuyahoga County. I  
10 wouldn't be able to say if or when he's done  
11 any --

12 MR. CHEFFO: Okay.

13 THE WITNESS: -- specific IN cases  
14 yet --

15 BY MR. CHEFFO:

16 Q. Is it --

17 A. -- this year.

18 Q. Is it fair to say that, to the  
19 extent he has, he would have received it; and  
20 if he hasn't, he wouldn't have?

21 MR. GALLUCCI: Object to form.

22 THE WITNESS: That's a fair  
23 statement.

24 BY MR. CHEFFO:

25 Q. And who is it that actually queries

1 the OARRS database in your office and puts them  
2 in the file?

3 A. That is done by different people.

4 Q. So a number of people have access?

5 A. No. So the OARRS access is tightly  
6 restricted. Dr. Gilson, myself. We just  
7 recently hired an epidemiologist through the  
8 grant that we are doing with Case Western. And  
9 so, as part of her duties, I've added that  
10 responsibility to do the lookups and do the  
11 printouts.

12 She brings them to me. And then I  
13 distribute them to the staff to put in the case  
14 files.

15 Q. So she's the one who queries the --  
16 the OARRS database; and if there is a hit or  
17 positive result, she prints it out, brings it  
18 to you; you put it in the files; and then it  
19 goes to the doctor?

20 A. Correct.

21 Q. Anybody else in -- in that chain?

22 A. Well, I put it in the basket in  
23 the -- in the general office. And each case  
24 manager will then -- the cases that they're  
25 assigned will take out of the basket their

1 OARRS files --

2 Q. Okay.

3 A. -- to add to the file.

4 Q. The case manager is an  
5 administrative type person?

6 A. Yes.

7 Q. And then -- and they are -- they  
8 have access to if OARRS data, which they then  
9 input and -- and -- well, let me strike that.

10 Does the case manager input the  
11 OARRS data anywhere else, or it is just the  
12 piece of paper that's printed out.

13 A. It's only the final report that gets  
14 added to the file.

15 Q. So the people who have access are  
16 the epidemiologist, yourself, the doctor, and  
17 the various case managers who assist the  
18 doctors in their duties?

19 MR. GALLUCCI: Object to form.

20 THE WITNESS: So the case managers  
21 have access only to that physical form, yes.

22 BY MR. CHEFFO:

23 Q. Well, that's --

24 A. They don't have access to the system  
25 itself.



1 Q. Understood.

2 Anybody else have access to the form  
3 or the system?

4 A. All the doctors will get the forms  
5 in the case file. At the moment, I don't  
6 believe anybody else has access to the OARRS  
7 system for our office.

8 Q. And do -- what is the  
9 epidemiologist's name?

10 A. Manreet Bhullar.

11 Q. And what is her function?

12 A. She is a epidemiologist.

13 Q. I understand.

14 But --

15 A. And she'll -- so she'll review, per  
16 the -- per the grant, a lot of the data that  
17 we've been talking about, 2015, '16 and '17,  
18 getting those finished, getting all the data  
19 compiled so that we can get it out.

20 Q. Have you had --

21 A. There are other duties, again,  
22 specific to the grant that aren't part of her  
23 duties that she discusses with the researchers  
24 at Case.

25 Q. Prior to this -- is she a doctor?

1           A.     No.  She's a -- she was a graduate  
2 student.

3           Q.     A master's of epidemiology?

4           A.     And she got her master's and -- no.

5           Q.     Okay.

6           A.     And has been hired.

7           Q.     Prior to this epidemiologist joining  
8 your group -- your -- your office as part of  
9 this grant, had you ever employed an  
10 epidemiologist?

11          A.     We never employed one, no.

12          Q.     Does she have a -- and does she have  
13 a -- is there a formal job description that  
14 you're aware of?

15          A.     There would have to be for her to be  
16 hired, yes.

17          Q.     And the -- and I just think I just  
18 have a -- another question or two.

19                 Was there any -- to your knowledge,  
20 any communications with the folks who run OARRS  
21 about using the database in the way that you  
22 have described to us today?

23                 MR. GALLUCCI:  Object to form.

24                 THE WITNESS:  As far as?

25                 BY MR. CHEFFO:

1           Q.       Well, for example, I mean did -- did  
2       you or someone at the department talk to the  
3       OARRS people or administrators and say, "We are  
4       going to query the database. We're going to  
5       print out a copy. We're going to allow the  
6       case managers to review it. We're going to put  
7       it in the files"?

8           A.       So the case managers do not review.  
9       They just simply pick up the report and put it  
10      in the appropriate file number.

11          Q.       Okay.

12                 MR. GALLUCCI: And object to form.

13                 Just give me a second --

14                 BY MR. CHEFFO:

15          Q.       Let me just ask you.

16                 I mean have you talked to -- have  
17      you talked at all with the OARRS people about  
18      printing out the copies and using it for  
19      your -- your doctors' purposes?

20          A.       I have not.

21          Q.       Do you know if anybody did?

22          A.       Dr. Gilson has his own  
23      conversations. He hasn't told me one way or  
24      the other if that was part of any of his  
25      discussions.

1                   The reports are for any  
2                   investigation -- investigative purposes for our  
3                   office to determine cause and manner of death.

4           Q.       And the last thing.

5                   I -- I pulled up this. And  
6                   unfortunately I'm going to read it to you. If  
7                   you need to get it, you can. It's off your web  
8                   site.

9                   But I went back and -- and look at  
10                  the 2012. Again, you could read it across the  
11                  table. This is the 2012 -- whoops -- report.

12                  MR. GALLUCCI: Which report are  
13                  you -- because we've talked about a couple  
14                  different types of reports.

15                  MR. CHEFFO: It's a statistical  
16                  report like the one that's in front of him.

17                  MR. GALLUCCI: Okay.

18                  THE WITNESS: Okay.

19                  BY MR. CHEFFO:

20       Q.       Right.

21                  And I'm -- I'd just direct your --  
22                  refresh your recollection.

23                  I think you told us that the -- the  
24                  words used in -- with respect to the Cuyahoga  
25                  County heroin initiative for 2015, '16, and '17

1       were inartful because they picked up the  
2       language of the U.S. President, and you would  
3       have rewritten them, right?

4           A.       I believe I said that --

5                   MR. GALLUCCI:   Object to form.

6                   THE WITNESS:   -- the report, as it  
7       was written, that all of those reports were  
8       done in the 2018 year.   And that was imprecise.  
9       But because of the declaration, yes, that --  
10      they were somewhat imprecise at that point.

11                  BY MR. CHEFFO:

12               Q.       They were imprecise because they  
13      used the words "public health emergency,"  
14      right?

15           A.       In part, yes.

16               Q.       And when was the 2012 statistical  
17      document published?

18                   Was that also done in 2018?

19           A.       No.

20               Q.       So this is what it says in 2012.

21                   MR. GALLUCCI:   I'm going to object  
22      to -- object to form.   But the use of a  
23      exhibit.   We're reading off a laptop here --

24                   MR. CHEFFO:   Fair enough.   But  
25      I'll --

1 MR. GALLUCCI: -- without production  
2 of any documents.

3 MR. CHEFFO: It's public document on  
4 the web site.

5 MR. GALLUCCI: That was produced in  
6 this litigation. It could have been  
7 available --

8 MR. CHEFFO: Okay.

9 MR. GALLUCCI: -- for an exhibit.

10 BY MR. CHEFFO:

11 Q. "The Cuyahoga County heroin  
12 initiative is broad" -- "is a broad response to  
13 a public health emergency."

14 That was used in 2012.

15 So does that refrect [sic] --  
16 refresh your recollection that none of that  
17 language has anything to do with President  
18 Trump's declaration?

19 MR. GALLUCCI: Same objection.

20 THE WITNESS: In 2012, no, that  
21 would not be.

22 BY MR. CHEFFO:

23 Q. And if the same language was used --  
24 carried on up until the 2017, that would  
25 refresh you recollection that the genesis of

1       that language had nothing to do with the  
2       president's declaration, did it?

3               MR. GALLUCCI:   Object to form.

4               THE WITNESS:   Likely not.   It was  
5       probably just a mistake that was carried  
6       through -- over and over again throughout the  
7       years, yes.

8               BY MR. CHEFFO:

9               Q.       A mistake that started back in 2012  
10       and continued on till today?

11              MR. GALLUCCI:   Object to form.

12              THE WITNESS:   Apparently the same  
13       language was used, stock --

14              MR. CHEFFO:    Okay.

15              THE WITNESS:   -- as we went forward.

16              MR. CHEFFO:    All right.   And we're  
17       going to break, consistent with the agreement  
18       that we put on the record earlier.

19              Thank you, sir.   I'm sure we'll have  
20       an opportunity to talk soon enough and look  
21       forward to continuing it after.

22              And thank you, Counsel.

23              MR. GALLUCCI:   Just for purpose of  
24       the record, can you please identify where we  
25       are in terms of time.

1 THE VIDEOGRAPHER: We're at 5 hours  
2 and 37 minutes and 37 seconds.

3 MR. BORANIAN: Okay. So let me  
4 ask -- before we go off, let me ask we'll need  
5 -- we'll need the exhibits back when we resume.

6 But will you keep custody of those,  
7 or want to give them to one of us?

8 Talking to the Court Reporter.

9 THE REPORTER: I will let you retain  
10 the exhibits.

11 MR. BORANIAN: Okay. Will one of  
12 the local attorneys be retaining the exhibits?

13 MR. GALLUCCI: I'm -- I'm happy to  
14 retain them. I'm here in the building. So I  
15 can --

16 MR. BORANIAN: Okay. Would you?

17 MR. GALLUCCI: I can retain the  
18 exhibits.

19 I also think, just because we're  
20 reconvening it, the transcript should not yet  
21 be prepared until this deposition's finalized.

22 Everybody in agreement?

23 MR. CHEFFO: We may get a -- a rough  
24 transcript so --

25 MR. GALLUCCI: Well, we're not



1 reconvening it for purposes of going it --  
2 going over and reexamining on questions that  
3 he's already provided testimony to. That's one  
4 of the things we discussed.

5 MR. CHEFFO: Yeah. Well, I -- I --  
6 again, I think we agreed that we were going to  
7 have a few extra hours. Like in any  
8 deposition, we're not going to keep going over  
9 things.

10 But if we want to look at a  
11 transcript -- because I may not be the one  
12 coming back, and we need to deal with it. But  
13 let -- we'll -- you know, if --

14 MR. GALLUCCI: That --

15 MR. CHEFFO: If you don't want to  
16 order a transcript, that's fine. But we can  
17 order a rough if we want to.

18 MR. GALLUCCI: That -- again, just  
19 noting for the record that part of the  
20 discussion was that we wouldn't be going back  
21 over the same stuff we had previously had  
22 testimony with regards to.

23 MR. CHEFFO: Yeah. Right. We won't  
24 do that.

25 MR. GALLUCCI: Okay. Thank you,

1 Counsel.

2 MR. CHEFFO: Sure.

3 THE VIDEOGRAPHER: We are going off  
4 the record at 4:29 p.m.

5 This concludes today's testimony of  
6 Hugh Shannon.

7 The total number of media units used  
8 was five and will be retained by Veritext Legal  
9 Solutions.

10 (Whereupon, the proceeding was  
11 adjourned at 4:29 p.m.)  
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C E R T I F I C A T E

I, Bonnie L. Russo, Certified Shorthand Reporter, and Notary Public, hereby certify:

That HUGH SHANNON was duly sworn by me, an authorized Notary Public, and that this deposition is a true and correct record of the testimony given by such witness to the best of my knowledge and ability.

I further certify that I am not related to any of the parties to this action and that I am in no way interested in the outcome of this matter.

In witness whereof, I have hereunto set my hand this day, January 28, 2019.

A handwritten signature in black ink, reading "Bonnie L. Russo", is written over a horizontal line.

Bonnie L. Russo

Certified Shorthand Reporter

Veritext Legal Solutions  
1100 Superior Ave  
Suite 1820  
Cleveland, Ohio 44114  
Phone: 216-523-1313

January 29, 2019

To: FRANK L. GALLUCCI, III, ESQ.

Case Name: In Re: National Prescription Opiate Litigation

Veritext Reference Number: 3196191

Witness: Hugh Shannon                      Deposition Date: 1/24/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to [production-midwest@veritext.com](mailto:production-midwest@veritext.com).

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,  
Production Department

NO NOTARY REQUIRED IN CA

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DEPOSITION REVIEW  
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3196191

CASE NAME: In Re: National Prescription Opiate Litigation

DATE OF DEPOSITION: 1/24/2019

WITNESS' NAME: Hugh Shannon

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

Date \_\_\_\_\_ Hugh Shannon

Sworn to and subscribed before me, a  
Notary Public in and for the State and County,  
the referenced witness did personally appear  
and acknowledge that:

They have read the transcript;

They signed the foregoing Sworn  
Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public

Commission Expiration Date

DEPOSITION REVIEW  
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3196191

CASE NAME: In Re: National Prescription Opiate Litigation

DATE OF DEPOSITION: 1/24/2019

WITNESS' NAME: Hugh Shannon

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Hugh Shannon

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;

They have listed all of their corrections in the appended Errata Sheet;

They signed the foregoing Sworn Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission Expiration Date

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ERRATA SHEET  
VERITEXT LEGAL SOLUTIONS MIDWEST  
ASSIGNMENT NO: 1/24/2019

PAGE/LINE(S) /	CHANGE	/REASON
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\_\_\_\_\_  
Date Hugh Shannon  
SUBSCRIBED AND SWORN TO BEFORE ME THIS \_\_\_\_\_  
DAY OF \_\_\_\_\_, 20\_\_\_\_\_.  
\_\_\_\_\_  
Notary Public  
\_\_\_\_\_  
Commission Expiration Date

[&amp; - 20111]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2016. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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